

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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 Facility ID Number: 0047332

Facility Name: Rainbow Beach Care Center

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

County: Cook

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

HFS ID Number: 203283565001

Date of Initial License for Current Owners: 08/01/05

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center# 0047332 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 bedsN/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>67,456</u>	<u>620</u>		<u>68,076</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>67,456</u>	<u>620</u>		<u>68,076</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.39%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 08/01/2005

J. Was the facility purchased or leased after January 1, 1978?

YES Date 08/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number
of beds certified _____ and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	276,595	23,357	10,761	310,713		310,713	5,282	315,995			1
2	Food Purchase		220,001		220,001		220,001	(20)	219,981			2
3	Housekeeping	210,901	57,785		268,686		268,686	(4,115)	264,571			3
4	Laundry	67,330	6,160	57,577	131,067		131,067	(412)	130,655			4
5	Heat and Other Utilities			195,893	195,893		195,893	2,745	198,638			5
6	Maintenance	293,463		139,308	432,771		432,771	(39,029)	393,742			6
7	Other (specify):*							2,205	2,205			7
8	TOTAL General Services	848,289	307,303	403,539	1,559,131		1,559,131	(33,344)	1,525,787			8
	B. Health Care and Programs											
9	Medical Director			5,350	5,350		5,350		5,350			9
10	Nursing and Medical Records	1,301,357	36,425	69,667	1,407,449		1,407,449	22,372	1,429,821			10
10a	Therapy							3,127	3,127			10a
11	Activities	130,648	4,015	1,397	136,060		136,060		136,060			11
12	Social Services	300,263	3,198	3,598	307,059		307,059	15,305	322,364			12
13	CNA Training											13
14	Program Transportation			60	60		60		60			14
15	Other (specify):*							6,115	6,115			15
16	TOTAL Health Care and Programs	1,732,268	43,638	80,072	1,855,978		1,855,978	46,919	1,902,897			16
	C. General Administration											
17	Administrative	104,146			104,146		104,146	51,166	155,312			17
18	Directors Fees											18
19	Professional Services			301,217	301,217		301,217	(238,312)	62,905			19
20	Dues, Fees, Subscriptions & Promotions			35,460	35,460		35,460	(10,060)	25,400			20
21	Clerical & General Office Expenses	79,772	15,374	134,764	229,910		229,910	66,004	295,914			21
22	Employee Benefits & Payroll Taxes			532,420	532,420		532,420	(1,973)	530,447			22
23	Inservice Training & Education			14	14		14		14			23
24	Travel and Seminar			2,933	2,933		2,933	4,507	7,440			24
25	Other Admin. Staff Transportation			5,621	5,621		5,621		5,621			25
26	Insurance-Prop.Liab.Malpractice			115,011	115,011		115,011	(606)	114,405			26
27	Other (specify):*							33,116	33,116			27
28	TOTAL General Administration	183,918	15,374	1,127,440	1,326,732		1,326,732	(96,158)	1,230,574			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,764,475	366,315	1,611,051	4,741,841		4,741,841	(82,583)	4,659,258			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rainbow Beach Care Center #0047332 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			35,051	35,051		35,051	394,383	429,434			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			45,497	45,497		45,497	810,297	855,794			32
33	Real Estate Taxes			181,108	181,108		181,108	11,613	192,721			33
34	Rent-Facility & Grounds			1,095,000	1,095,000		1,095,000	(1,090,202)	4,798			34
35	Rent-Equipment & Vehicles			4,309	4,309		4,309	1,285	5,594			35
36	Other (specify):*											36
37	TOTAL Ownership			1,360,965	1,360,965		1,360,965	127,376	1,488,341			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,120		2,120		2,120	(724)	1,396			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,523	115,523		115,523		115,523			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		2,120	115,523	117,643		117,643	(724)	116,919			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,764,475	368,435	3,087,539	6,220,449		6,220,449	44,069	6,264,518			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending: 12/31/06

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(625,505)	30		9
10	Interest and Other Investment Income	(768)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	(282)	21		18
19	Entertainment				19
20	Contributions	(6,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(104,193)	21		24
25	Fund Raising, Advertising and Promotional	(10,601)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(566)	20		28
29	Other-Attach Schedule	(216,328)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (964,263)		\$	30

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	2	
		Amount	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)	1,008,332		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,008,332		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 44,069		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	2	3	4	
		Yes	No	Amount	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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48		49		50	51
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Other Income	21
2	Patent Clothing	19
3	Theft Loss	23
4	Miscellaneous Administrative Expenses-Building C	23
5	Administration Building Company	31
6	Non-Allowable Legal	19
7	Elevator Repair Receipts	06
8	Related Party Interest	32
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101	Total	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			576				4,706					5,282	1
2	Food Purchase	(20)											(20)	2
3	Housekeeping										(4,115)		(4,115)	3
4	Laundry										(412)		(412)	4
5	Heat and Other Utilities			2,627			118						2,745	5
6	Maintenance	(50,000)		3,984	6,810	78	78		21				(39,029)	6
7	Other (specify):*				985	415		805					2,205	7
8	TOTAL General Services	(50,020)		7,187	7,795	493	196	5,511	21		(4,527)		(33,344)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(587)						25,202			(2,243)		22,372	10
10a	Therapy							3,127					3,127	10a
11	Activities													11
12	Social Services				3,759			11,546					15,305	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				504			5,611					6,115	15
16	TOTAL Health Care and Programs	(587)			4,263			45,486			(2,243)		46,919	16
	C. General Administration													
17	Administrative			2,565	5,690			42,911					51,166	17
18	Directors Fees													18
19	Professional Services	(30,397)		(98,512)			(109,403)						(238,312)	19
20	Fees, Subscriptions & Promotions	(17,167)		7,059			48						(10,060)	20
21	Clerical & General Office Expenses	(123,328)	1,220	14,750	161,737	(463)	36	12,095			(43)		66,004	21
22	Employee Benefits & Payroll Taxes					(713)				(1,260)			(1,973)	22
23	Inservice Training & Education													23
24	Travel and Seminar			4,456			51						4,507	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			(633)			27						(606)	26
27	Other (specify):*				24,971	652		7,493					33,116	27
28	TOTAL General Administration	(170,892)	1,220	(70,315)	192,398	(524)	(109,241)	62,499		(1,260)	(43)		(96,158)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(221,499)	1,220	(63,128)	204,456	(31)	(109,045)	113,496	21	(1,260)	(6,813)		(82,583)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06 Ending:

12/31/06

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	(625,505)	1,006,586	12,677			349		276				394,383	30
31	Amortization of Pre-Op. & Org.	(22,961)	22,961											31
32	Interest	(94,298)	873,836	29,732			997		30				810,297	32
33	Real Estate Taxes		9,213	2,171			229						11,613	33
34	Rent-Facility & Grounds		(1,095,000)	4,798									(1,090,202)	34
35	Rent-Equipment & Vehicles			1,285									1,285	35
36	Other (specify):*													36
37	TOTAL Ownership	(742,764)	817,596	50,663			1,575		306				127,376	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(600)		(124)		(724)	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								(600)		(124)		(724)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(964,263)	818,816	(12,465)	204,456	(31)	(107,470)	113,496	(273)	(1,260)	(6,937)		44,069	45

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Rainbow Beach Real Estate		Building Co.

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent	\$ 1,095,000	Rainbow Beach Real Estate	100.00%	\$	\$ (1,095,000)	1
2	V	33 Additional RE Taxes	181,108	Rainbow Beach Real Estate	100.00%		(181,108)	2
3	V	21 Miscellaneous Administrative		Rainbow Beach Real Estate	100.00%	1,220	1,220	3
4	V	30 Depreciation		Rainbow Beach Real Estate	100.00%	1,006,586	1,006,586	4
5	V	31 Amortization		Rainbow Beach Real Estate	100.00%	22,961	22,961	5
6	V	33 Real Estate Tax Expense		Rainbow Beach Real Estate	100.00%	190,321	190,321	6
7	V	32 Interest Expense		Rainbow Beach Real Estate	100.00%	873,836	873,836	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,276,108			\$ 2,094,924	\$ * 818,816	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center# 0047332Report Period Beginning: 01/01/06Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization					
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 576	576	15	
16	V	05	Utilities		Care Centers, Inc.	100.00%	2,627	2,627	16	
17	V	06	Maintenance		Care Centers, Inc.	100.00%	3,984	3,984	17	
18	V								18	
19	V	17	Administration		Care Centers, Inc.	100.00%	2,565	2,565	19	
20	V	19	Professional Fees	117,969	Care Centers, Inc.	100.00%	19,457	(98,512)	20	
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	7,059	7,059	21	
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	14,750	14,750	22	
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	4,456	4,456	23	
24	V	26	Insurance		Care Centers, Inc.	100.00%	(633)	(633)	24	
25	V	30	Depreciation		Care Centers, Inc.	100.00%	12,677	12,677	25	
26	V	32	Interest		Care Centers, Inc.	100.00%	29,732	29,732	26	
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,171	2,171	27	
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,798	4,798	28	
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,285	1,285	29	
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			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			\$ 117,969			\$ 105,504	\$ * (12,465)	39	

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	06	Maintenance Salary	Care Centers, Inc.	100.00%	6,810	6,810		15
16	V	07	Emp. Ben. - Gen. Serv.	Care Centers, Inc.	100.00%	985	985		16
17	V	10	Nursing Salary	Care Centers, Inc.	100.00%				17
18	V	10a	Rehab Salary	Care Centers, Inc.	100.00%				18
19	V	12	Social Service Salary	Care Centers, Inc.	100.00%	3,759	3,759		19
20	V	15	Emp. Ben. - Healthcare	Care Centers, Inc.	100.00%	504	504		20
21	V	17	Administration Salary	Care Centers, Inc.	100.00%	5,690	5,690		21
22	V	21	Office Salary	Care Centers, Inc.	100.00%	161,737	161,737		22
23	V	27	Emp. Ben. - Gen. Admin.	Care Centers, Inc.	100.00%	24,971	24,971		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		\$			\$ 204,456	\$ *	204,456	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Maintenance Salary	1,172	Care Centers, Inc.	100.00%	1,250	78	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	415	415	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%			21
22	V	21	Office Salary	3,816	Care Centers, Inc.	100.00%	3,353	(463)	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	652	652	23
24	V								24
25	V	22	Employee Benefits	713				(713)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 5,701			\$ 5,670	\$ *	(31) 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	19	Professional Fees	\$ 109,908	Care Centers Clinical, Inc.	100.00%	\$ 505	\$ (109,403)	15
16	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	48	48	16
17	V	21	Office and Clerical		Care Centers Clinical, Inc.	100.00%	36	36	17
18	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	51	51	18
19	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	349	349	19
20	V	32	Interest		Care Centers Clinical, Inc.	100.00%	997	997	20
21	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	118	118	21
22	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	78	78	22
23	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	27	27	23
24	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	229	229	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		\$ 109,908				\$ 2,438	\$ * (107,470)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	01	Dietary Salary	\$	Care Centers Clinical, Inc.	100.00%	\$ 4,706	\$ 4,706	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	805	805	16
17	V	10	Nursing Salary		Care Centers Clinical, Inc.	100.00%	25,202	25,202	17
18	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	3,127	3,127	18
19	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	11,546	11,546	19
20	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	5,611	5,611	20
21	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	42,911	42,911	21
22	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	12,095	12,095	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	7,493	7,493	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		\$				\$ 113,496	\$ * 113,496	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 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 21	\$ 21	15
16	V	30	Depreciation		Vent Lease, LLC.	100.00%	276	276	16
17	V	32	Interest		Vent Lease, LLC.	100.00%	30	30	17
18	V	39	Vent/Ancillary Reimbursement	600	Vent Lease, LLC.	100.00%		(600)	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			\$ 600			\$ 327	\$ * (273)	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 BENEFIT GROUP	100.00%	\$ 62,221	\$ 62,221	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	63,481	CCS EMPLOYEE BENEFIT GROUP	100.00%		(63,481)	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			\$ 63,481			\$ 62,221	\$ * (1,260)	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	01 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	03 Housekeeping	50,736	Xcel Supply, LLC	100.00%	46,622	(4,115)	16
17	V	04 Laundry	5,083	Xcel Supply, LLC	100.00%	4,670	(412)	17
18	V	06 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	27,663	Xcel Supply, LLC	100.00%	25,419	(2,243)	19
20	V	11 Activities		Xcel Supply, LLC	100.00%			20
21	V	12 Social Service		Xcel Supply, LLC	100.00%			21
22	V	20 Dues, Fees, Subscriptions & Promotions		Xcel Supply, LLC	100.00%			22
23	V	21 Clerical & General Office	530	Xcel Supply, LLC	100.00%	487	(43)	23
24	V	22 Employee Benefits		Xcel Supply, LLC	100.00%			24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary	1,525	Xcel Supply, LLC	100.00%	1,401	(124)	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		\$ 85,537			\$ 78,600	\$ * (6,937)	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Eric Rothner	Shareholder	Administrative	51.00%	See Attached	1.43	3.10%	Alloc. Salary	\$ 2,334	17-7	1
2	Gale Rothner	Shareholder	Administrative	49.00%	See Attached	1.50	4.29%	Alloc. Salary	3,334	17-7	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.35	4.27%	Alloc. Salary	5,709	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 11,377		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending: 12/31/06

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Care Centers, Inc.
 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 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	01	Dietary	Patient Days	1,592,658	31	\$ 13,468	\$ 68,076	\$ 576	1
2	05	Utilities	Patient Days	1,592,658	31	61,456	68,076	2,627	2
3	06	Maintenance	Patient Days	1,592,658	31	93,209	68,076	3,984	3
4									4
5	17	Administration	Patient Days	1,592,658	31	60,000	68,076	2,565	5
6	19	Professional Fees	Patient Days	1,592,658	31	455,203	68,076	19,457	6
7	20	Dues and Subscriptions	Patient Days	1,592,658	31	165,158	68,076	7,059	7
8	21	Office & Clerical	Patient Days	1,592,658	31	345,085	68,076	14,750	8
9	24	Travel and Seminar	Patient Days	1,592,658	31	104,250	68,076	4,456	9
10	26	Insurance	Patient Days	1,592,658	31	(14,814)	68,076	(633)	10
11	30	Depreciation	Patient Days	1,592,658	31	296,584	68,076	12,677	11
12	32	Interest	Patient Days	1,592,658	31	695,586	68,076	29,732	12
13	33	Real Estate Taxes	Patient Days	1,592,658	31	50,799	68,076	2,171	13
14	34	Rent - Building	Patient Days	1,592,658	31	112,256	68,076	4,798	14
15	35	Rent - Equipment & Auto	Patient Days	1,592,658	31	30,066	68,076	1,285	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,468,306	\$	\$ 105,504	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Care Centers, Inc.
 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 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	06	Maintenance Salary	Patient Days	1,592,658	31	159,318	159,318	68,076	6,810	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	31	23,038		68,076	985	2
3	10	Nursing Salary	Patient Days	1,592,658	31			68,076		3
4	10a	Rehab Salary	Patient Days	1,592,658	31			68,076		4
5	12	Social Service Salary	Patient Days	1,592,658	31	87,938	87,938	68,076	3,759	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	31	11,794		68,076	504	6
7	17	Administration Salary	Patient Days	1,592,658	31	133,122	133,122	68,076	5,690	7
8	21	Office Salary	Patient Days	1,592,658	31	3,783,895	3,783,895	68,076	161,737	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	31	584,195		68,076	24,971	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					\$ 4,783,299	\$ 4,164,272		\$ 204,456	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Care Centers, Inc.
 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 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	06	Maintenance Salary	Direct Allocation	26	366,540	366,540		1,250	1
2	07	Emp. Ben. - Gen. Serv.	Direct Allocation	26	60,795			415	2
3									3
4									4
5									5
6									6
7									7
8	21	Office Salary	Direct Allocation	23	418,249	418,249		3,353	8
9	27	Emp. Ben. - Gen. Admin.	Direct Allocation	23	70,744			652	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				\$ 916,329	\$ 784,790		\$ 5,670	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Care Centers Clinical, Inc.
 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 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	19	Professional Fees	Patient Days	1,592,658	30	\$ 11,820	\$ 68,076	\$ 505	1
2	20	Dues and Subscriptions	Patient Days	1,592,658	30	1,118	68,076	48	2
3	21	Office and Clerical	Patient Days	1,592,658	30	847	68,076	36	3
4	24	Travel and Seminar	Patient Days	1,592,658	30	1,201	68,076	51	4
5	30	Depreciation	Patient Days	1,592,658	30	8,167	68,076	349	5
6	32	Interest	Patient Days	1,592,658	30	23,321	68,076	997	6
7	05	Utilities	Patient Days	1,592,658	30	2,749	68,076	118	7
8	06	Maintenance	Patient Days	1,592,658	30	1,817	68,076	78	8
9	26	Insurance	Patient Days	1,592,658	30	623	68,076	27	9
10	33	Real Estate Taxes	Patient Days	1,592,658	30	5,358	68,076	229	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					\$ 57,020	\$	\$ 2,438	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Care Centers Clinical, Inc.
 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 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	01	Dietary Salary	Patient Days	1,592,658	30	110,093	110,093	68,076	4,706	1
2	07	Emp. Ben. - Gen. Serv.	Patient Days	1,592,658	30	18,826	18,826	68,076	805	2
3	10	Nursing Salary	Patient Days	1,592,658	30	589,608		68,076	25,202	3
4	10a	Rehab Salary	Patient Days	1,592,658	30	73,158	73,158	68,076	3,127	4
5	12	Social Service Salary	Patient Days	1,592,658	30	270,126	270,126	68,076	11,546	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,592,658	30	131,280		68,076	5,611	6
7	17	Administration Salary	Patient Days	1,592,658	30	1,003,912		68,076	42,911	7
8	21	Office Salary	Patient Days	1,592,658	30	282,969	282,969	68,076	12,095	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,592,658	30	175,293		68,076	7,493	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					\$ 2,655,265	\$ 755,172		\$ 113,496	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Vent Lease, LLC
 Street Address 2201 W. Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 674-1180
 Fax Number (847) 673-7741

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	06	Repairs	Direct Billing	868,537	31	\$ 30,521	\$ 600	\$ 21	1
2	30	Depreciation	Direct Billing	868,537	31	400,000	600	276	2
3	32	Interest	Direct Billing	868,537	31	43,063	600	30	3
4	39	Vent/Ancillary Reimbursement							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					\$ 473,584	\$	\$ 327	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

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	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 62,221	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				\$	\$		\$ 62,221	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending: 12/31/06

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 Xcel Supply, LLC
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

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	01	Dietary	Direct Allocation		\$	\$		\$	1
2	03	Housekeeping	Direct Allocation					46,622	2
3	04	Laundry	Direct Allocation					4,670	3
4	06	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					25,419	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees, Subscriptions & Prom	Direct Allocation						8
9	21	Clerical & General Office	Direct Allocation					487	9
10	22	Employee Benefits	Direct Allocation						10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation					1,401	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				\$	\$		\$ 78,600	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending: 12/31/06

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	CIB		X	Mortgage			\$	10,040,625		\$	666,947	1								
2	Lake Forest Bank		X	Mortgage				2,665,701			113,359	2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Lake Forest Bank		X	Line of Credit				605,702			45,497	6								
7	South Shore Properties	.						180,000			63,681	7								
8	See Supplemental Schedule							350,000			(32,922)	8								
9	TOTAL Facility Related						\$	13,842,028		\$	856,562	9								
B. Non-Facility Related*																				
10	Interest Income		X								(768)	10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$			\$	(768)	14								
15	TOTALS (line 9+line14)						\$	13,842,028		\$	855,794	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number

Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

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

	1	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	TOTAL Long-Term											7						
Working Capital																		
8	Hunter Management	X					\$	\$ 350,000			\$ 29,849	8						
9	Alloc. From Care Centers										30,729	9						
10	Alloc. From Vent Lease										30	10						
11	Less: Related Party Interest										(93,530)	11						
12												12						
13												13						
14	TOTAL Working Capital							350,000			(32,922)	14						
B. Non-Facility Related*																		
15							\$	\$			\$	15						
16												16						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related											20						

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rainbow Beach Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047332

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-30-112-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,385.50</u>	\$ <u>1,385.50</u>
2. <u>21-30-112-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>12,124.03</u>	\$ <u>12,124.03</u>
3. <u>21-30-112-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>13,480.76</u>	\$ <u>13,480.76</u>
4. <u>21-30-112-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>215.67</u>	\$ <u>215.67</u>
5. <u>21-30-112-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>215.67</u>	\$ <u>215.67</u>
6. <u>21-30-112-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>33,250.29</u>	\$ <u>33,250.29</u>
7. <u>21-30-112-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>42,124.42</u>	\$ <u>42,124.42</u>
8. <u>21-30-112-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>856.06</u>	\$ <u>856.06</u>
9. <u>21-30-112-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>860.79</u>	\$ <u>860.79</u>
10. <u>21-30-112-051-0000</u>	<u>Long Term Care Property</u>	\$ <u>77,267.88</u>	\$ <u>77,267.88</u>
	TOTALS	\$ <u>181,781.07</u>	\$ <u>181,781.07</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rainbow Beach Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047332

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-30-112-052-0000</u>	<u>Long Term Care Property</u>	\$ <u>6,539.45</u>	\$ <u>6,539.45</u>
2. <u>See Attached</u>	<u>Home Office Allocation</u>	\$ <u>116,388.47</u>	\$ <u>2,128.91</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u>122,927.92</u>	\$ <u>8,668.36</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Rainbow Beach Care Center

0047332 Report Period Beginning:

01/01/06 Ending:

12/31/06

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	<u>Facility</u>			\$ <u>485,009</u>	1
2	<u>Allocation From Care Centers</u>			<u>14,999</u>	2
3	TOTALS			\$ 500,008	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rainbow Beach Care Center**

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		9,549,265	510,455		244,853	(265,602)	489,706	67
68		58,864	1,668		2,439	771	9,713	68
69			35,051			(35,051)		69
70		\$ 9,608,129	\$ 547,174		\$ 247,292	\$ (299,882)	\$ 499,419	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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		\$ 9,608,129	\$ 547,174		\$ 247,292	\$ (299,882)	\$ 499,419	1
2	Security System	2005	33,668		20	1,683	1,683	1,683	2
3	Elevator Pre-Maintenace	2005	6,000		20	300	300	300	3
4	Remodeling	2006	82,800		20	4,140	4,140	4,140	4
5	Replace Circuits & Keys	2006	3,600		20	180	180	180	5
6	Heating Coil Replacement	2006	6,738		20	337	337	337	6
7	Air Vent System Installation	2006	5,550		20	278	278	278	7
8	Boiler Expansion Tank Replacement	2006	3,706		20	185	185	185	8
9	Boiler Reapirs	2006	3,951		20	198	198	198	9
10	Freight Elevator Repair	2006	15,700		20	785	785	785	10
11	Elevator Cylinder Repair & Install	2006	53,200		20	2,660	2,660	2,660	11
12	Install Flooring	2006	3,450		20	173	173	173	12
13	Window Replacement	2006	33,250		20	1,663	1,663	1,663	13
14	New Water & Drain Connections	2006	3,048		20	152	152	152	14
15	Nurse Call System 1St Floor	2006	26,000		20	1,300	1,300	1,300	15
16	Laminated Cabinets	2006	8,108		20	405	405	405	16
17	Overhaul Hvac System	2006	28,500		20	1,425	1,425	1,425	17
18	Complete Violaton Repairs	2006	7,531		20	377	377	377	18
19	Bathroom Leak Repair	2006	9,200		20	460	460	460	19
20	Basement Drainage System	2006	18,300		20	915	915	915	20
21	Fire Damper Replacement	2006	2,786		20	139	139	139	21
22	Elevator Door And Fuse Replacement	2006	2,635		20	132	132	132	22
23	Aluminum Windows	2006	6,334		20	317	317	317	23
24	Sewage Pump System	2006	5,240		20	262	262	262	24
25	Call Light Boxes	2006	6,728		20	336	336	336	25
26	Nurse Call System Installment	2006	1,811		20	91	91	91	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,985,963	\$ 547,174		\$ 266,184	\$ (280,990)	\$ 518,311	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number **Rainbow Beach Care Center**

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 9,985,963	\$ 547,174		\$ 266,184	\$ (280,990)	\$ 518,311	1
2									2
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XI. OWNERSHIP COSTS (continued)

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XI. OWNERSHIP COSTS (continued)

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

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XI. OWNERSHIP COSTS (continued)

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Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

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Facility Name & ID Number **Rainbow Beach Care Center**

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

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

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XI. OWNERSHIP COSTS (continued)

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XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
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Report Period Beginning:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
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XI. OWNERSHIP COSTS (continued)

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XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	211		2005	1960	\$ 9,549,265	\$ 510,455	39	\$ 244,853	\$ (265,602)	\$ 489,706	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		9,549,265	510,455		244,853	(265,602)	489,706	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4		Allocation From Care Centers Clinical	2002	2002	\$ 1,972	\$ 51	39	\$ 51	\$	\$ 217	4
5		Allocation From Care Centers, Inc. 2201 Main	2002	2002	18,697	479	39	479		2,058	5
6											6
7											7
8											8
Improvement Type**											
9		Allocation From Care Centers Clinical		2002	1,629	68	20	81	13	367	9
10		Allocation From Care Centers Clinical		2003	1,920	37	20	96	59	336	10
11		Allocation From Care Centers Clinical		2005	95	4	20	5	1	7	11
12											12
13		Allocation From Care Centers, Inc. 2201 Main		2002	15,445	643	20	772	129	3,475	13
14		Allocation From Care Centers, Inc. 2201 Main		2003	18,202	346	20	910	564	3,185	14
15		Allocation From Care Centers, Inc. 2201 Main		2005	904	40	20	45	5	68	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
		58,864	1,668		2,439	771	9,713	

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,460,919	\$ 507,203	\$ 158,823	\$ (348,380)	10	\$ 367,500	71
72	Current Year Purchases	19,509	62	1,777	1,715	10	1,777	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,480,428	\$ 507,265	\$ 160,601	\$ (346,664)		\$ 369,277	75

D. Vehicle Depreciation (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		Allocation From Care Centers Cli	2006	\$ 1,870	\$ 127	\$ 127	\$	5	\$ 127	76
77		Allocation From Care Centers, In	2006	28,872		2,252	2,252	5	21,719	77
78		Allocation From Care Centers, In	2006	1,865	373	270	(103)	5	270	78
79										79
80	TOTALS			\$ 32,607	\$ 500	\$ 2,649	\$ 2,149		\$ 22,116	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)	\$ 11,999,006	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,054,939	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 429,434	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (625,505)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 909,704	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Allocation From Care Centers				4,798			6
7	TOTAL				\$ 4,798			7

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 5,593 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	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	39 - 02	# of prescripts				1,557		1,557	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						563		563	13
14	TOTAL			\$		\$	\$ 2,120		\$ 2,120	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center# 0047332Report Period Beginning: 01/01/06

Ending:

12/31/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,500	\$ 54,526	1
2	Cash-Patient Deposits	18,677	18,677	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	2,684,782	2,684,782	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	122,419	122,419	6
7	Other Prepaid Expenses	5,327	5,327	7
8	Accounts Receivable (owners or related parties)		1,575,075	8
9	Other(specify): <u>See Attached Schedule</u>	650	650	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,833,355	\$ 4,461,456	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		9,549,265	14
15	Leasehold Improvements, at Historical Cost	266,826	266,826	15
16	Equipment, at Historical Cost	138,252	1,467,175	16
17	Accumulated Depreciation (book methods)	(36,255)	(1,247,791)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		81,711	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(30,004)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	1,503,526	1,503,526	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,872,349	\$ 12,075,717	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,705,704	\$ 16,537,173	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 376,004	\$ 376,005	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,465	18,465	28
29	Short-Term Notes Payable	1,135,702	1,135,702	29
30	Accrued Salaries Payable	215,824	215,824	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,825	9,825	31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,576	108,576	32
33	Accrued Interest Payable		61,733	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	1,637,376	1,637,376	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,501,772	\$ 3,563,506	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		12,706,326	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 12,706,326	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,501,772	\$ 16,269,832	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,203,932	\$ 267,341	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,705,704	\$ 16,537,173	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (28,955)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (28,955)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,420,487	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	(398,600)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Capital Contributions	211,000	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,232,887	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)	\$ 1,203,932	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center# 0047332Report Period Beginning: 01/01/06Ending: 12/31/06**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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,573,152	1
2	Discounts and Allowances for all Levels	(234)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,572,918	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	234	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(208)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 26	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	768	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 768	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	67,224	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 67,224	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,640,936	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,559,131	31
32	Health Care	1,855,978	32
33	General Administration	1,326,732	33
B. Capital Expense			
34	Ownership	1,360,965	34
C. Ancillary Expense			
35	Special Cost Centers	2,120	35
36	Provider Participation Fee	115,523	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,220,449	40
41	Income before Income Taxes (line 30 minus line 40)**	1,420,487	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,420,487	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,987	2,274	\$ 87,132	\$ 38.32	1
2	Assistant Director of Nursing	1,842	2,063	55,453	26.88	2
3	Registered Nurses	3,100	3,217	82,801	25.74	3
4	Licensed Practical Nurses	19,036	19,855	444,819	22.40	4
5	CNAs & Orderlies	60,624	65,312	612,909	9.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,718	1,763	22,105	12.54	9
10	Activity Assistants	9,006	9,931	108,543	10.93	10
11	Social Service Workers	19,748	21,377	300,263	14.05	11
12	Dietician	866	882	8,731	9.90	12
13	Food Service Supervisor	1,771	1,983	44,748	22.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,149	7,927	142,300	17.95	15
16	Dishwashers	16,798	17,826	80,816	4.53	16
17	Maintenance Workers	25,319	27,699	293,463	10.59	17
18	Housekeepers	23,618	25,510	210,901	8.27	18
19	Laundry	7,639	8,269	67,330	8.14	19
20	Administrator	2,027	2,211	104,146	47.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,597	4,953	79,772	16.11	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	2,066	2,172	18,243	8.40	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	208,911	225,224	\$ 2,764,475 *	\$ 12.27	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	246	\$ 10,761	01-03	35
36	Medical Director	Monthly	5,350	09-03	36
37	Medical Records Consultant	Monthly	3,294	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,065	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	29	1,397	11-03	44
45	Social Service Consultant	75	3,598	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	350	\$ 27,465		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	6	\$ 213	10-03	50
51	Licensed Practical Nurses	1,818	63,095	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,824	\$ 63,308		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

Report Period Beginning: 01/01/06 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES No 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. \$ 115,523
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT