



Facility Name & ID Number Rainbow Beach Care Center# 0047332 Report Period Beginning: 01/01/07 Ending: 12/31/07

## III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<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			
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>71,171</u>	<u>359</u>		<u>71,530</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>71,171</u>	<u>359</u>		<u>71,530</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 92.88%

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

3,594 (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 X 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: 12/31/2007 Fiscal Year: 12/31/2007

\* 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: 01/01/07 Ending: 12/31/07

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	272,235	21,426	11,225	304,886		304,886	4,448	309,334		1
2	Food Purchase		242,401		242,401		242,401	355	242,756		2
3	Housekeeping	203,928	40,627		244,555		244,555	(1,722)	242,833		3
4	Laundry	82,188	7,033	43,984	133,205		133,205	(358)	132,847		4
5	Heat and Other Utilities			195,543	195,543		195,543	2,809	198,352		5
6	Maintenance	247,953		134,642	382,595		382,595	12,174	394,769		6
7	Other (specify):*							1,598	1,598		7
8	<b>TOTAL General Services</b>	<b>806,304</b>	<b>311,487</b>	<b>385,394</b>	<b>1,503,185</b>		<b>1,503,185</b>	<b>19,304</b>	<b>1,522,489</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,450	9,450		9,450		9,450		9
10	Nursing and Medical Records	1,290,575	47,606	22,843	1,361,024		1,361,024	29,856	1,390,880		10
10a	Therapy							3,170	3,170		10a
11	Activities	133,593	4,268	2,384	140,245		140,245		140,245		11
12	Social Services	338,282	4,661	5,128	348,071		348,071	9,102	357,173		12
13	CNA Training										13
14	Program Transportation			311	311		311		311		14
15	Other (specify):*							5,848	5,848		15
16	<b>TOTAL Health Care and Programs</b>	<b>1,762,450</b>	<b>56,535</b>	<b>40,116</b>	<b>1,859,101</b>		<b>1,859,101</b>	<b>47,976</b>	<b>1,907,077</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	102,803			102,803		102,803	70,320	173,123		17
18	Directors Fees										18
19	Professional Services			334,572	334,572	(68,295)	266,277	(221,568)	44,709		19
20	Dues, Fees, Subscriptions & Promotions			40,528	40,528		40,528	(1,502)	39,026		20
21	Clerical & General Office Expenses	112,366	14,761	206,808	333,935		333,935	30,360	364,295		21
22	Employee Benefits & Payroll Taxes			531,947	531,947		531,947	(553)	531,394		22
23	Inservice Training & Education			2,982	2,982		2,982		2,982		23
24	Travel and Seminar			3,326	3,326		3,326	1,990	5,316		24
25	Other Admin. Staff Transportation			9,227	9,227		9,227	1,682	10,909		25
26	Insurance-Prop.Liab.Malpractice			115,258	115,258		115,258	1,722	116,980		26
27	Other (specify):*							38,026	38,026		27
28	<b>TOTAL General Administration</b>	<b>215,169</b>	<b>14,761</b>	<b>1,244,648</b>	<b>1,474,578</b>	<b>(68,295)</b>	<b>1,406,283</b>	<b>(79,523)</b>	<b>1,326,760</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,783,923</b>	<b>382,783</b>	<b>1,670,158</b>	<b>4,836,864</b>	<b>(68,295)</b>	<b>4,768,569</b>	<b>(12,243)</b>	<b>4,756,326</b>		<b>29</b>

\*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: 01/01/07 Ending: 12/31/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>D. Ownership</b>										
30	Depreciation			72,776	72,776		72,776	383,911	456,687		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			14,515	14,515		14,515	900,625	915,140		32
33	Real Estate Taxes			226,266	226,266	68,295	294,561	3,395	297,956		33
34	Rent-Facility & Grounds			1,140,000	1,140,000		1,140,000	(1,136,565)	3,435		34
35	Rent-Equipment & Vehicles			3,956	3,956		3,956	459	4,415		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,457,513	1,457,513	68,295	1,525,808	151,825	1,677,633		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		1,025	1,009	2,034		2,034		2,034		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	<b>TOTAL Special Cost Centers</b>		1,025	116,532	117,557		117,557		117,557		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,783,923	383,808	3,244,203	6,411,934		6,411,934	139,583	6,551,517		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: 01/01/07

Ending: 12/31/07

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(336,438)	30		9
10	Interest and Other Investment Income	(817)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(12)	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	(275)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,437)	21		24
25	Fund Raising, Advertising and Promotional	(8,968)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(133,460)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (541,407)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	680,990		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 680,990</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ 139,583</b>		<b>37</b>

\*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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Rainbow Beach Care Center  
 ID# 0047332  
 Report Period Beginning: 01/01/07  
 Ending: 12/31/07

Sch. V Line

NON-ALLOWABLE EXPENSES		
	Amount	Reference
1	Other Income	(36) 21 1
2	Patent Clothing	248 19 2
3	Price Period Fees	(14,118) 21 3
4	2006 Legal Fees	(100) 19 4
5	Misc. Administrative Expense- Building Co.	(250) 21 5
6	Amortization- Building Co.	(28,458) 31 6
7	Annual Report	(250) 20 7
8	Non-Allowable Office Expense	(90,000) 21 8
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101	Total	(133,460) 101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning:

01/01/07

Ending:

12/31/07

## 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)	
	<b>A. General Services</b>													
1	Dietary			298	4,221		(71)						4,448	1
2	Food Purchase	(12)		367									355	2
3	Housekeeping			559	56		(2,337)						(1,722)	3
4	Laundry						(358)						(358)	4
5	Heat and Other Utilities			2,665	144								2,809	5
6	Maintenance			12,096	18	60							12,174	6
7	Other (specify):*			1,197	401								1,598	7
8	<b>TOTAL General Services</b>	<b>(12)</b>		<b>17,182</b>	<b>4,840</b>	<b>60</b>	<b>(2,766)</b>						<b>19,304</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(248)			32,805		(2,701)						29,856	10
10a	Therapy				3,170								3,170	10a
11	Activities													11
12	Social Services				9,102								9,102	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				5,848								5,848	15
16	<b>TOTAL Health Care and Programs</b>	<b>(248)</b>			<b>50,925</b>		<b>(2,701)</b>						<b>47,976</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			12,718	57,602								70,320	17
18	Directors Fees													18
19	Professional Services	(100)		(109,417)	(112,051)								(221,568)	19
20	Fees, Subscriptions & Promotions	(9,218)		7,681	35								(1,502)	20
21	Clerical & General Office Expenses	(166,116)	250	184,736	14,911	(3,421)							30,360	21
22	Employee Benefits & Payroll Taxes			(553)	(59)		59						(553)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,299	691								1,990	24
25	Other Admin. Staff Transportation			1,682									1,682	25
26	Insurance-Prop.Liab.Malpractice			1,704	18								1,722	26
27	Other (specify):*			28,234	9,792								38,026	27
28	<b>TOTAL General Administration</b>	<b>(175,434)</b>	<b>250</b>	<b>128,084</b>	<b>(29,061)</b>	<b>(3,421)</b>	<b>59</b>						<b>(79,523)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(175,694)</b>	<b>250</b>	<b>145,266</b>	<b>26,704</b>	<b>(3,361)</b>	<b>(5,408)</b>						<b>(12,243)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	(336,438)	696,378	21,728	913	1,330							383,911	30
31	Amortization of Pre-Op. & Org.	(28,458)	28,458											31
32	Interest	(817)	855,292	40,999	3,930	1,221							900,625	32
33	Real Estate Taxes			3,180	215								3,395	33
34	Rent-Facility & Grounds		(1,140,000)	3,435									(1,136,565)	34
35	Rent-Equipment & Vehicles			452	7								459	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(365,713)</b>	<b>440,128</b>	<b>69,794</b>	<b>5,065</b>	<b>2,551</b>							<b>151,825</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(541,407)</b>	<b>440,378</b>	<b>215,060</b>	<b>31,769</b>	<b>(810)</b>	<b>(5,408)</b>						<b>139,583</b>	<b>45</b>

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning:

01/01/07

Ending:

12/31/07

**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	\$ 1,140,000	Rainbow Beach Real Estate	100.00%	\$	\$ (1,140,000)	1
2	V	21 Miscellaneous Administrative		Rainbow Beach Real Estate	100.00%	250	250	2
3	V	30 Depreciation Expense		Rainbow Beach Real Estate	100.00%	696,378	696,378	3
4	V	31 Amortization Expense		Rainbow Beach Real Estate	100.00%	28,458	28,458	4
5	V	32 Interest Expense		Rainbow Beach Real Estate	100.00%	855,292	855,292	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,140,000			\$ 1,580,378	\$ * 440,378	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: 01/01/07Ending: 12/31/07

## 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%	\$ 298	\$ 298	15	
16	V	02	Food		Care Centers, Inc.	100.00%	367	367	16	
17	V	03	Housekeeping		Care Centers, Inc.	100.00%	559	559	17	
18	V	05	Utilities		Care Centers, Inc.	100.00%	2,665	2,665	18	
19	V	06	Maintenance		Care Centers, Inc.	100.00%	4,395	4,395	19	
20	V	17	Administrative		Care Centers, Inc.	100.00%	2,662	2,662	20	
21	V	19	Professional Fees	123,469	Care Centers, Inc.	100.00%	14,052	(109,417)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	7,681	7,681	22	
23	V	21	Office and Clerical		Care Centers, Inc.	100.00%	22,259	22,259	23	
24	V	24	Seminar and Travel		Care Centers, Inc.	100.00%	1,299	1,299	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc.	100.00%	1,682	1,682	25	
26	V	26	Insurance		Care Centers, Inc.	100.00%	1,704	1,704	26	
27	V	30	Depreciation		Care Centers, Inc.	100.00%	21,728	21,728	27	
28	V	32	Interest		Care Centers, Inc.	100.00%	40,999	40,999	28	
29	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	3,180	3,180	29	
30	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,435	3,435	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	452	452	31	
32	V	06	Maintenance	1,151	Care Centers, Inc.	100.00%	8,852	7,701	32	
33	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,197	1,197	33	
34	V	17	Administrative		Care Centers, Inc.	100.00%	10,056	10,056	34	
35	V	21	Office and Clerical	2,646	Care Centers, Inc.	100.00%	165,123	162,477	35	
36	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	28,234	28,234	36	
37	V	22	Employee Benefits	553	Care Centers, Inc.	100.00%		(553)	37	
38	V								38	
39	Total			\$ 127,819			\$ 342,879	\$ * 215,060	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# 0047332Report Period Beginning: 01/01/07Ending: 12/31/07

## 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	03	Housekeeping	\$	Care Centers Clinical, Inc.	100.00%	\$ 56	\$ 56	15	
16	V	05	Utilities		Care Centers Clinical, Inc.	100.00%	144	144	16	
17	V	06	Maintenance		Care Centers Clinical, Inc.	100.00%	18	18	17	
18	V	19	Professional Fees	114,454	Care Centers Clinical, Inc.	100.00%	2,403	(112,051)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc.	100.00%	35	35	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc.	100.00%	141	141	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc.	100.00%	691	691	21	
22	V	26	Insurance		Care Centers Clinical, Inc.	100.00%	18	18	22	
23	V	30	Depreciation		Care Centers Clinical, Inc.	100.00%	913	913	23	
24	V	32	Interest		Care Centers Clinical, Inc.	100.00%	3,930	3,930	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc.	100.00%	215	215	25	
26	V	35	Rent - Equipment & Auto		Care Centers Clinical, Inc.	100.00%	7	7	26	
27	V	01	Dietary Salary		Care Centers Clinical, Inc.	100.00%	4,221	4,221	27	
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc.	100.00%	401	401	28	
29	V	10	Nursing Salary	392	Care Centers Clinical, Inc.	100.00%	33,197	32,805	29	
30	V	10a	Rehab Salary		Care Centers Clinical, Inc.	100.00%	3,170	3,170	30	
31	V	12	Social Service Salary		Care Centers Clinical, Inc.	100.00%	9,102	9,102	31	
32	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc.	100.00%	5,848	5,848	32	
33	V	17	Administration Salary		Care Centers Clinical, Inc.	100.00%	57,602	57,602	33	
34	V	21	Office Salary		Care Centers Clinical, Inc.	100.00%	14,770	14,770	34	
35	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc.	100.00%	9,792	9,792	35	
36	V	22	Employee Benefits	59	Care Centers Clinical, Inc.	100.00%		(59)	36	
37	V								37	
38	V								38	
39	Total			\$ 114,905			\$ 146,674	\$ * 31,769	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	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 60	\$ 60	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%			16
17	V	30	Depreciation		Vent Lease, LLC.	100.00%	471	471	17
18	V	32	Interest		Vent Lease, LLC.	100.00%	39	39	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	859	859	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	1,182	1,182	20
21	V	21	Office and Clerical	3,421	Vent Lease, LLC.	100.00%		(3,421)	21
22	V	39	Ancillary		Vent Lease, LLC.	100.00%			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		\$ 3,421				\$ 2,611	\$ * (810)	39

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

Facility Name & ID Number Rainbow Beach Care Center# 0047332Report Period Beginning: 01/01/07Ending: 12/31/07

## 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	1 Dietary	\$ 881	Xcel Supply, LLC	100.00%	\$ 810	\$ (71)	15
16	V	3 Housekeeping	28,974	Xcel Supply, LLC	100.00%	26,637	(2,337)	16
17	V	4 Laundry	4,440	Xcel Supply, LLC	100.00%	4,082	(358)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	33,484	Xcel Supply, LLC	100.00%	30,784	(2,701)	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 And Subscriptions		Xcel Supply, LLC	100.00%			22
23	V	21 Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22 Employee Benefits	3,606	Xcel Supply, LLC	100.00%	3,665	59	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39 Ancillary		Xcel Supply, LLC	100.00%			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		\$ 71,385			\$ 65,978	\$ * (5,408)	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	22	Employee Health Insurance	\$	CCS Employee Benefit Group	100.00%	\$ 39,107	\$ 39,107	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	39,107	CCS Employee Benefit Group	100.00%		(39,107)	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			\$ 39,107			\$ 39,107	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning: 01/01/07

Ending: 12/31/07

**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

**VII. RELATED PARTIES (continued)**

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/07 Ending: 12/31/07

## 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%	See Attached	1.46	3.16%	Alloc. Salary	\$	17-7	1
2	Mark Steinberg	Relative	Administrative	N/A	See Attached	2.4	4.36%	Alloc. Salary	5,899	17-7	2
3	Adam Vales	Relative	Clerical	N/A	See Attached	0.24	0.60%	Alloc. Salary	337	22-7	3
4	Kim Rudolph	Relative	Clerical	N/A	See Attached	0.21	0.60%	Alloc. Salary	185	22-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 6,421		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: 01/01/07

Ending: 12/31/07

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:

01/01/07Ending: 12/31/07

## 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

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

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	01	Dietary	Patient Days	1,625,640	33	\$ 6,823	\$ 70,954	\$ 298	1
2	02	Food	Patient Days	1,625,640	33	8,403	70,954	367	2
3	03	Housekeeping	Patient Days	1,625,640	33	12,807	70,954	559	3
4	05	Utilities	Patient Days	1,625,640	33	61,054	70,954	2,665	4
5	06	Maintenance	Patient Days	1,625,640	33	100,693	70,954	4,395	5
6	17	Administrative	Patient Days	1,625,640	33	61,000	70,954	2,662	6
7	19	Professional Fees	Patient Days	1,625,640	33	321,947	70,954	14,052	7
8	20	Dues and Subscriptions	Patient Days	1,625,640	33	175,974	70,954	7,681	8
9	21	Office and Clerical	Patient Days	1,625,640	33	509,990	70,954	22,259	9
10	24	Seminar and Travel	Patient Days	1,625,640	33	29,773	70,954	1,299	10
11	25	Other Staff Admin. Trans.	Patient Days	1,625,640	33	38,529	70,954	1,682	11
12	26	Insurance	Patient Days	1,625,640	33	39,041	70,954	1,704	12
13	30	Depreciation	Patient Days	1,625,640	33	497,823	70,954	21,728	13
14	32	Interest	Patient Days	1,625,640	33	939,326	70,954	40,999	14
15	33	Real Estate Taxes	Patient Days	1,625,640	33	72,865	70,954	3,180	15
16	34	Rent - Building	Patient Days	1,625,640	33	78,695	70,954	3,435	16
17	35	Rent - Equipment & Auto	Patient Days	1,625,640	33	10,366	70,954	452	17
18	06	Maintenance	Patient Days	1,625,640	33	187,019	187,019	8,163	18
19	06	Maintenance	Direct Allocation			456,812	456,812	689	19
20	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	33	91,856	70,954	1,197	20
21	17	Administrative	Patient Days	1,625,640	33	230,402	230,402	10,056	21
22	21	Office and Clerical	Patient Days	1,625,640	33	3,779,534	3,779,534	164,965	22
23	21	Office and Clerical	Direct Allocation			489,346	489,346	158	23
24	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	33	691,109	70,954	28,234	24
25	TOTALS					\$ 8,891,187	\$ 5,143,115	\$ 342,879	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center# 0047332

Report Period Beginning:

01/01/07Ending: 12/31/07

## 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 Care Center 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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,625,640	32	\$ 1,294	\$ 70,954	\$ 56	1	
2	05	Utilities	Patient Days	1,625,640	32	3,307	70,954	144	2	
3	06	Maintenance	Patient Days	1,625,640	32	410	70,954	18	3	
4	19	Professional Fees	Patient Days	1,625,640	32	55,053	70,954	2,403	4	
5	20	Dues and Subscriptions	Patient Days	1,625,640	32	809	70,954	35	5	
6	21	Office & Clerical	Patient Days	1,625,640	32	3,220	70,954	141	6	
7	24	Travel and Seminar	Patient Days	1,625,640	32	15,843	70,954	691	7	
8	26	Insurance	Patient Days	1,625,640	32	409	70,954	18	8	
9	30	Depreciation	Patient Days	1,625,640	32	20,909	70,954	913	9	
10	32	Interest	Patient Days	1,625,640	32	90,038	70,954	3,930	10	
11	33	Real Estate Taxes	Patient Days	1,625,640	32	4,921	70,954	215	11	
12	35	Rent - Equipment & Auto	Patient Days	1,625,640	32	155	70,954	7	12	
13	01	Dietary Salary	Patient Days	1,625,640	32	96,717	96,717	70,954	4,221	13
14	07	Emp. Ben. - Gen. Serv.	Patient Days	1,625,640	32	9,180	70,954	401	14	
15	10	Nursing Salary	Patient Days	1,625,640	32	751,308	751,308	70,954	32,792	15
16	10a	Rehab Salary	Patient Days	1,625,640	32	72,628	72,628	70,954	3,170	16
17	12	Social Service Salary	Patient Days	1,625,640	32	208,543	208,543	70,954	9,102	17
18	15	Emp. Ben. - Healthcare	Patient Days	1,625,640	32	133,126	70,954	5,811	18	
19	17	Administration Salary	Patient Days	1,625,640	32	1,319,729	1,319,729	70,954	57,602	19
20	21	Office Salary	Patient Days	1,625,640	32	338,399	338,399	70,954	14,770	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	1,625,640	32	224,344	70,954	9,792	21	
22	10	Nursing Salary	Direct Allocation			13,379	13,379		405	22
23	12	Social Service Salary	Direct Allocation			8,845	8,845			23
24	15	Emp. Ben. - Healthcare	Direct Allocation			1,994			37	24
25	TOTALS					\$ 3,374,561	\$ 2,809,547		\$ 146,674	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	892,186	27	\$ 35,557	\$	1,500	\$ 60	1
2	21	Office and Clerical	Direct Billing	892,186	27	44		1,500		2
3	30	Depreciation	Direct Billing	892,186	27	280,000		1,500	471	3
4	32	Interest	Direct Billing	892,186	27	23,404		1,500	39	4
5	30	Depreciation	Patient Days	1,625,640	33	19,677		70,954	859	5
6	32	Interest	Patient Days	1,625,640	33	27,081		70,954	1,182	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					\$ 385,762	\$		\$ 2,611	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	1	Dietary	Direct Allocation			\$		\$ 810	1
2	3	Housekeeping	Direct Allocation					26,637	2
3	4	Laundry	Direct Allocation					4,082	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					30,784	5
6	11	Activities	Direct Allocation						6
7	12	Social Service	Direct Allocation						7
8	20	Dues, Fees And Subscriptions	Direct Allocation						8
9	21	Office And Clerical	Direct Allocation						9
10	22	Employee Benefits	Direct Allocation					3,665	10
11	24	Seminars & Education	Direct Allocation						11
12	39	Ancillary	Direct Allocation						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					\$	\$	65,978	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning: 01/01/07

Ending: 12/31/07

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 Benefit Group, Inc.  
 Street Address 2201 W. 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		\$	\$		\$ 39,107	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				\$	\$		\$ 39,107	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning: 01/01/07

Ending: 12/31/07

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

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning:

01/01/07

Ending: 12/31/07

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

**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	Name of Lender	2		3	4	5	6		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	CIB		X	Mortgage			\$	\$ 9,859,126			\$ 655,345	1					
2	Lake Forest Bank		X	Mortgage				2,627,274			199,947	2					
3												3					
4												4					
5	See Supplemental Schedule											5					
<b>Working Capital</b>																	
6	Lake Forest Bank		X	Line of Credit				550,000			14,370	6					
7	VGM Financial		X	Furniture				82,618				7					
8	See Supplemental Schedule										145	8					
9	<b>TOTAL Facility Related</b>						\$	\$ 13,119,018			\$ 869,807	9					
<b>B. Non-Facility Related*</b>																	
10	Interest Income										(817)	10					
11												11					
12												12					
13	See Supplemental Schedule										46,150	13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 45,333	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$ 13,119,018			\$ 915,140	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:

01/01/07

Ending:

12/31/07

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

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1							\$	\$			\$									
2																				
3																				
4																				
5																				
6																				
7	<b>TOTAL Long-Term</b>																			
<b>Working Capital</b>																				
8	<b>Fox Valley</b>						\$	\$			\$ 145									
9																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Working Capital</b>										145									
<b>B. Non-Facility Related*</b>																				
15	<b>Care Centers, Inc.</b>		X				\$	\$			\$ 40,999									
16	<b>Care Centers Clinical, Inc.</b>		X								3,930									
17	<b>Vent Lease, LLC</b>		X								1,221									
18																				
19																				
20	<b>TOTAL Non-Facility Related</b>										46,150									

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

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

Facility Name & ID Number Rainbow Beach Care Center# 0047332 Report Period Beginning: 01/01/07Ending: 12/31/07

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2006 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>98,699</b>	1																			
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	<b>210,208</b>	2																			
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>111,509</b>	3																			
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>118,152</b>	4																			
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>68,295</b>	5																			
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6																			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>297,956</b>	7																			
Real Estate Tax History:																								
Real Estate Tax Bill for Calendar Year:																								
2002	<u>189,965</u>	8	<table border="1"> <tr> <td colspan="3"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2006</td> <td>\$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5</td> <td>\$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6</td> <td>\$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION</td> <td>\$</td> <td>16</td> </tr> </table>			<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2006	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
<b>FOR BHF USE ONLY</b>																								
13	FROM R. E. TAX STATEMENT FOR 2006	\$				13																		
14	PLUS APPEAL COST FROM LINE 5	\$				14																		
15	LESS REFUND FROM LINE 6	\$				15																		
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																					
2003	<u>185,455</u>	9																						
2004	<u>186,422</u>	10																						
2005	<u>188,321</u>	11																						
2006	<u>206,813</u>	12																						
<u>2006 Taxes Paid In 2007 \$206,813 X 5% (Est. Increase) =\$217,153</u>																								
<u>Less: First 2007 Payable In 2008 (99,002) Equals \$118,151</u>																								
<u>Allocation From Care Centers \$3,181 CC Clinical \$215</u>																								
<u>Beg Accrual Adjusted for Prepayment of 2008 R/E Bill</u>																								

## NOTES:

- Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

**2006 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 2006 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 2006.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-30-112-004-0000</u>	<u>Long Term Care Property</u>	<u>\$ 1,149.05</u>	<u>\$ 1,149.05</u>
2. <u>21-30-112-007-0000</u>	<u>Long Term Care Property</u>	<u>\$ 30,958.22</u>	<u>\$ 30,958.22</u>
3. <u>21-30-112-008-0000</u>	<u>Long Term Care Property</u>	<u>\$ 34,801.96</u>	<u>\$ 34,801.96</u>
4. <u>21-30-112-011-0000</u>	<u>Long Term Care Property</u>	<u>\$ 243.89</u>	<u>\$ 243.89</u>
5. <u>21-30-112-012-0000</u>	<u>Long Term Care Property</u>	<u>\$ 243.89</u>	<u>\$ 243.89</u>
6. <u>21-30-112-013-0000</u>	<u>Long Term Care Property</u>	<u>\$ 29,303.57</u>	<u>\$ 29,303.57</u>
7. <u>21-30-112-014-0000</u>	<u>Long Term Care Property</u>	<u>\$ 37,109.49</u>	<u>\$ 37,109.49</u>
8. <u>21-30-112-017-0000</u>	<u>Long Term Care Property</u>	<u>\$ 734.59</u>	<u>\$ 734.59</u>
9. <u>21-30-112-018-0000</u>	<u>Long Term Care Property</u>	<u>\$ 739.15</u>	<u>\$ 739.15</u>
10. <u>21-30-112-051-0000</u>	<u>Long Term Care Property</u>	<u>\$ 65,830.22</u>	<u>\$ 65,830.22</u>
	<b>TOTALS</b>	<u>\$ 201,114.03</u>	<u>\$ 201,114.03</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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>5,698.64</u>	\$ <u>5,698.64</u>
2. <u>See Attached</u>	<u>Care Centers, Inc.</u>	\$ <u>46,662.50</u>	\$ <u>2,036.67</u>
3. <u>See Attached</u>	<u>Care Centers Building, LLC.</u>	\$ <u>24,152.48</u>	\$ <u>1,054.18</u>
4. <u>See Attached</u>	<u>Care Centers Clinical</u>	\$ <u>4,834.42</u>	\$ <u>211.01</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>81,348.04</u>	\$ <u>9,000.50</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:

01/01/07 Ending:

12/31/07

**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>17,427</u>	2
3	<b>TOTALS</b>			\$ <b>502,436</b>	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning:

01/01/07

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12/31/07

**XI. OWNERSHIP COSTS (continued)**

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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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:

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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	
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
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57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		9,549,625	398,699		244,853	(153,846)	734,559	67
68		97,966	5,147		5,147		32,253	68
69			72,776			(72,776)		69
70		\$ 9,647,591	\$ 476,622		\$ 250,000	\$ (226,622)	\$ 766,812	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Rainbow Beach Care Center

# 0047332

Report Period Beginning:

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Ending:

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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	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 9,647,591	\$ 476,622		\$ 250,000	\$ (226,622)	\$ 766,812	1
2	Lectro-Loc Security System	2005	33,668		20	1,683	1,683	3,647	2
3	Elevator Pre-Maintenance	2005	6,000		20	300	300	650	3
4	Remodeling Down Payment	2006	32,800		20	1,640	1,640	3,280	4
5	Replace Existing Curcuits And Keys	2006	3,600		20	180	180	360	5
6	Remodeling Installment	2006	25,000		20	1,250	1,250	2,396	6
7	Freight Elevator Repair	2006	15,700		20	785	785	1,439	7
8	Install Vct Flooring	2006	3,450		20	173	173	316	8
9	Window Replacement	2006	33,250		20	1,663	1,663	3,048	9
10	Remodeling Installment	2006	25,000		20	1,250	1,250	2,188	10
11	New Water & Drain Connections	2006	3,048		20	152	152	267	11
12	Nurse Call System On 1St Floor	2006	26,000		20	1,300	1,300	2,275	12
13	Custom Built Laminated Cabinets	2006	8,108		20	405	405	709	13
14	Complete Violation Repairs	2006	7,531		20	377	377	565	14
15	Bathroom Leak Repair	2006	9,200		20	460	460	652	15
16	Basement Drainage System	2006	18,300		20	915	915	1,296	16
17	Fire Damper Replacement	2006	2,786		20	139	139	197	17
18	Nurse Call System Installment	2006	1,811		20	91	91	113	18
19	Install Aluminum Windows In Community Room	2006	6,334		20	317	317	369	19
20	Sewage Pump System	2006	5,240		20	262	262	284	20
21	Heating Coil Replacement	2006	6,738		20	1,348	1,348	2,695	21
22	Air Vent System Installation	2006	5,550		20	1,110	1,110	2,127	22
23	Boiler Expansion Tank Replacement	2006	3,706		20	741	741	1,421	23
24	Boiler Repairs	2006	3,951		20	790	790	1,515	24
25	Overhaul Hvac System	2006	28,500		20	1,425	1,425	2,256	25
26	Elevator Door And Fuse Replacement	2006	2,635		20	527	527	747	26
27	Elevator Cylinder Repair And Install	2006	53,200		20	10,640	10,640	15,073	27
28	Installed New Boxes For Call Lights	2006	6,728		20	1,346	1,346	1,458	28
29	Foundation Work - Repair On Drainage System	2007	31,230		20	1,431	1,431	1,431	29
30	Remodel - Shower Stalls	2007	32,400		20	810	810	810	30
31	Repair - Laundry Rm Leakage	2007	11,700		20	293	293	293	31
32	Catch Basin & Asphalt Repair	2007	2,782		20	58	58	58	32
33	Installation Of Fire Damper Actuators	2007	12,362		20	294	294	294	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,115,899	\$ 476,622		\$ 284,155	\$ (192,467)	\$ 821,041	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:

01/01/07

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,115,899	\$ 476,622		\$ 284,155	\$ (192,467)	\$ 821,041	1
2	New Boiler	2007	10,763		20	149	149	149	2
3	New Fire Alarm System	2007	29,789		20	709	709	709	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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

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Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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

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Report Period Beginning:

01/01/07

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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# 0047332

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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:

01/01/07

Ending:

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**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12L, Carried Forward</b>		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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

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Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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12									12
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,156,451	\$ 476,622		\$ 285,013	\$ (191,609)	\$ 821,899	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:

01/01/07

Ending:

12/31/07

**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	211		2005	1960	\$ 9,549,625	\$ 398,699	39	\$ 244,853	\$ (153,846)	\$ 734,559	4
5											5
6											6
7											7
8											8
<b>Improvement Type**</b>											
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:

01/01/07

Ending:

12/31/07

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	<b>9,549,625</b>	\$	<b>398,699</b>	\$	<b>244,853</b>	\$	<b>(153,846)</b>	\$	<b>734,559</b>	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:

01/01/07

Ending:

12/31/07

**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		2201 Main LLC Allocation	2002	2002	\$ 19,436	\$ 498		\$ 498	\$	\$ 2,637	4
5		Care Centers Clinical Allocation	2002	2002	2,014	52		52		273	5
6		Hillside (Storage and Training)	1996	1996	32,957	845		845		9,331	6
7											7
8											8
		<b>Improvement Type**</b>									
9		Hillside (Storage and Training)		1996	556	-	20	-		556	9
10		Hillside (Storage and Training)		1997	3,165	102	20	102		1,506	10
11											11
12		Care Centers, Inc.		2007	201	13	20	13		13	12
13											13
14		2201 Main LLC Allocation		2002	16,056	1,467	20	1,467		7,351	14
15		2201 Main LLC Allocation		2003	18,921	1,729	20	1,729		8,663	15
16		2201 Main LLC Allocation		2005	940	100	20	100		239	16
17											17
18		Care Centers Clinical Allocation		2002	1,663	152	20	152		762	18
19		Care Centers Clinical Allocation		2003	1,960	179	20	179		897	19
20		Care Centers Clinical Allocation		2005	97	10	20	10		25	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:

01/01/07

Ending:

12/31/07

**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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$ 97,966		\$ 5,147	\$ 5,147	\$ 32,253	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: 01/01/07 Ending: 12/31/07

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	\$ 1,484,879	\$ 313,760	\$ 154,422	\$ (159,338)	10	\$ 526,772	71
72	Current Year Purchases	119,995		14,509	14,509	10	14,509	72
73	Fully Depreciated Assets	1,070	150	150		10	150	73
74								74
75	TOTALS	\$ 1,605,944	\$ 313,910	\$ 169,081	\$ (144,829)		\$ 541,431	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	Care Centers, Inc.	Allocation	2007	\$ 36,667	\$ 2,127	\$ 2,127	\$	5	\$ 30,120	76
77	Care Centers Clinical, Inc.	Allocation	2007	3,137	464	464		5	593	77
78										78
79										79
80	TOTALS			\$ 39,804	\$ 2,591	\$ 2,591	\$		\$ 30,713	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)	\$ 12,304,635	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 793,123	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 456,685	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (336,438)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,394,043	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 Cost Centers				3,435			6
7	TOTAL				\$ 3,435			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 4,415

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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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					
					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 - 03	# of prescripts			1,009	275		1,284	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						750		750	13
14	<b>TOTAL</b>			\$		\$ 1,009	\$ 1,025		\$ 2,034	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: 01/01/07

Ending:

12/31/07

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,500	\$ 117,956	1
2	Cash-Patient Deposits	14,544	14,544	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	2,018,881	2,018,881	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	121,373	121,373	6
7	Other Prepaid Expenses	5,228	5,228	7
8	Accounts Receivable (owners or related parties)		1,575,075	8
9	Other(specify): <u>See Attached Schedule</u>	100,000	100,000	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,261,526	\$ 3,953,057	10
	<b>B. Long-Term Assets</b>			
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	436,105	436,105	15
16	Equipment, at Historical Cost	219,994	1,548,917	16
17	Accumulated Depreciation (book methods)	(109,031)	(2,016,945)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		81,711	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(58,462)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,050,594	\$ 11,529,126	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,312,120	\$ 15,482,183	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 372,477	\$ 372,478	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,993	15,993	28
29	Short-Term Notes Payable	550,000	550,000	29
30	Accrued Salaries Payable	240,783	240,783	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,506	11,506	31
32	Accrued Real Estate Taxes(Sch.IX-B)	118,152	118,152	32
33	Accrued Interest Payable		60,630	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	1,649,938	1,649,938	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,958,849	\$ 3,019,480	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	82,618	82,618	39
40	Mortgage Payable		12,486,400	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 82,618	\$ 12,569,018	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,041,467	\$ 15,588,498	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,270,653	\$ (106,315)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,312,120	\$ 15,482,183	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,203,932	1
2	Restatements (describe):		2
3	<u>Rounding</u>	7	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,203,939	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,537,714	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	(1,471,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 66,714	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 1,270,653	24 *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center# 0047332Report Period Beginning: 01/01/07Ending: 12/31/07**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,948,858	1
2	Discounts and Allowances for all Levels	(277)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,948,581	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	275	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(107)	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 168	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	817	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 817	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	82	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 82	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,949,648	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,503,185	31
32	Health Care	1,859,101	32
33	General Administration	1,474,578	33
<b>B. Capital Expense</b>			
34	Ownership	1,457,513	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,034	35
36	Provider Participation Fee	115,523	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,411,934	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,537,714	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,537,714	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: 01/01/07

Ending:

12/31/07

**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	1,935	2,162	\$ 79,969	\$ 36.99	1
2	Assistant Director of Nursing	1,875	2,146	62,897	29.31	2
3	Registered Nurses	2,667	2,906	74,571	25.66	3
4	Licensed Practical Nurses	16,551	17,670	404,990	22.92	4
5	CNAs & Orderlies	64,530	68,610	650,395	9.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,988	2,191	26,926	12.29	9
10	Activity Assistants	8,472	9,577	106,667	11.14	10
11	Social Service Workers	17,574	18,942	286,788	15.14	11
12	Dietician	1,974	2,210	26,021	11.77	12
13	Food Service Supervisor	1,829	2,028	32,218	15.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,463	8,148	85,160	10.45	15
16	Dishwashers	14,475	15,428	128,836	8.35	16
17	Maintenance Workers	19,654	21,653	247,953	11.45	17
18	Housekeepers	21,878	23,712	203,928	8.60	18
19	Laundry	8,755	9,719	82,188	8.46	19
20	Administrator	1,901	2,175	102,803	47.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,107	7,878	112,366	14.26	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	1,843	2,044	17,753	8.69	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	10,653	10,875	51,494	4.74	33
34	TOTAL (lines 1 - 33)	213,124	230,074	\$ 2,783,923 *	\$ 12.10	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	258	\$ 11,225	01-03	35
36	Medical Director	Monthly	9,450	09-03	36
37	Medical Records Consultant	Monthly	2,314	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,434	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	48	2,384	11-03	44
45	Social Service Consultant	126	5,128	12-03	45
46	Other(specify)				46
47	<u>Medical Records Consultant</u>	<u>See Attached</u>	392	10-03	47
48					48
49	TOTAL (lines 35 - 48)	432	\$ 33,327		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	16	\$ 889	10-03	50
51	Licensed Practical Nurses	468	16,814	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	484	\$ 17,703		53

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Rainbow Beach Care Center

Report Period Beginning: 01/01/07 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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
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? Yes  
If YES, give association name and amount. See Attached
- (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. \$ 60 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ No 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. \$ 100% in Ln 14  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 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 \$5,000, 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