

Facility Name & ID Number Rainbow Beach Care Center

0047332 Report Period Beginning: 01/01/08 Ending: 12/31/08

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>77,226</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>77,226</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	<u>68,234</u>	<u>156</u>		<u>68,390</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>68,234</u>	<u>156</u>		<u>68,390</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.56%

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

4,055 (Do not include bed-hold days in Section B.)

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

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

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

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

YES NO

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

Date started 08/01/05

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

YES Date 08/01/05 NO

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	295,984	28,250	9,051	333,285		333,285	4,799	338,084		1
2	Food Purchase		265,612		265,612		265,612	584	266,196		2
3	Housekeeping	223,380	52,223		275,603		275,603	(1,415)	274,188		3
4	Laundry	57,536	12,788	65,322	135,646		135,646	(304)	135,342		4
5	Heat and Other Utilities			241,204	241,204		241,204	3,614	244,818		5
6	Maintenance	334,786		153,974	488,760		488,760	13,002	501,762		6
7	Other (specify):*							3,229	3,229		7
8	TOTAL General Services	911,686	358,873	469,551	1,740,110		1,740,110	23,509	1,763,619		8
	B. Health Care and Programs										
9	Medical Director			10,000	10,000		10,000		10,000		9
10	Nursing and Medical Records	1,433,642	44,337	10,737	1,488,716		1,488,716	31,930	1,520,646		10
10a	Therapy							3,098	3,098		10a
11	Activities	127,350	7,016	200	134,566		134,566		134,566		11
12	Social Services	419,794	4,624	5,696	430,114		430,114	17,895	448,009		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*							8,433	8,433		15
16	TOTAL Health Care and Programs	1,980,786	55,977	26,633	2,063,396		2,063,396	61,356	2,124,752		16
	C. General Administration										
17	Administrative	119,550		37,029	156,579		156,579	65,492	222,071		17
18	Directors Fees										18
19	Professional Services			378,828	378,828		378,828	(278,246)	100,582		19
20	Dues, Fees, Subscriptions & Promotions			54,122	54,122		54,122	(16,109)	38,013		20
21	Clerical & General Office Expenses	105,712	19,186	129,153	254,051		254,051	173,768	427,819		21
22	Employee Benefits & Payroll Taxes			587,004	587,004		587,004	(2,197)	584,807		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,385	7,385		7,385	2,176	9,561		24
25	Other Admin. Staff Transportation			10,998	10,998		10,998	1,655	12,653		25
26	Insurance-Prop.Liab.Malpractice			117,861	117,861		117,861	1,232	119,093		26
27	Other (specify):*							34,499	34,499		27
28	TOTAL General Administration	225,262	19,186	1,322,380	1,566,828		1,566,828	(17,731)	1,549,097		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,117,734	434,036	1,818,564	5,370,334		5,370,334	67,133	5,437,467		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center #0047332 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	
	D. Ownership											
30	Depreciation			103,059	103,059		103,059	369,446	472,505			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,422	46,422		46,422	1,292,762	1,339,184			32
33	Real Estate Taxes			202,287	202,287		202,287	5,591	207,878			33
34	Rent-Facility & Grounds			1,800,000	1,800,000		1,800,000	(1,795,927)	4,073			34
35	Rent-Equipment & Vehicles			4,278	4,278		4,278	1,351	5,629			35
36	Other (specify):*											36
37	TOTAL Ownership			2,156,046	2,156,046		2,156,046	(126,777)	2,029,269			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,840	115,840		115,840		115,840			42
43	Other (specify):*			648	648		648	(648)				43
44	TOTAL Special Cost Centers			116,488	116,488		116,488	(648)	115,840			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,117,734	434,036	4,091,098	7,642,868		7,642,868	(60,292)	7,582,576			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: 01/01/08

Ending: 12/31/08

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	(166,632)	30		9
10	Interest and Other Investment Income	(314)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	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	(830)	21		18
19	Entertainment				19
20	Contributions	(9,250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,173)	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	(206,304)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (392,509)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	332,217		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 332,217		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (60,292)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Rainbow Beach Care Center

ID# 0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Jury Duty Income	\$ (34)	10	1
2	Patient Clothing	(427)	10	2
3	Collections Expense	(8)	21	3
4	Building Co. - Filing Fee	(250)	21	4
5	Building Co. - Consulting Fee	(120,000)	19	5
6	Building Co. - Amortization	(53,007)	36	6
7	Annual Report	(250)	20	7
8	Prior Period Legal Fees	(3,645)	19	8
9	Public Relations	(648)	43	9
10	Alliance for Living Political Action Committee	(5,064)	20	10
11	Non-Allowable Expense	(22,971)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(206,304)		49

Rainbow Beach Care Center

ID# 0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			575		4,224							4,799	1
2	Food Purchase	(6)		590									584	2
3	Housekeeping			569		63	(2,047)						(1,415)	3
4	Laundry						(304)						(304)	4
5	Heat and Other Utilities			3,469		145							3,614	5
6	Maintenance			4,384	8,463	18			137				13,002	6
7	Other (specify):*				2,681	548							3,229	7
8	TOTAL General Services	(6)		9,587	11,144	4,998	(2,351)		137				23,509	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(461)				36,216	(2,675)		(1,150)				31,930	10
10a	Therapy					3,098							3,098	10a
11	Activities													11
12	Social Services					17,895							17,895	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					8,433							8,433	15
16	TOTAL Health Care and Programs	(461)				65,642	(2,675)		(1,150)				61,356	16
	C. General Administration													
17	Administrative			2,759	10,280	52,453							65,492	17
18	Directors Fees													18
19	Professional Services	(123,645)	120,000	(159,781)		(114,820)							(278,246)	19
20	Fees, Subscriptions & Promotions	(23,737)		7,618		10							(16,109)	20
21	Clerical & General Office Expenses	(24,059)	250	33,231	160,086	17,816			(13,556)				173,768	21
22	Employee Benefits & Payroll Taxes			(1,970)			(227)						(2,197)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,951		225							2,176	24
25	Other Admin. Staff Transportation			1,654					1				1,655	25
26	Insurance-Prop.Liab.Malpractice			1,209		20			3				1,232	26
27	Other (specify):*				25,442	9,057							34,499	27
28	TOTAL General Administration	(171,441)	120,250	(113,329)	195,808	(35,239)	(227)		(13,552)				(17,731)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(171,908)	120,250	(103,742)	206,952	35,401	(5,254)		(14,565)				67,133	29

STATE OF ILLINOIS

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/08 Ending:

Summary B

12/31/08

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	(166,632)	509,933	15,350		1,083			9,712				369,446	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(314)	1,239,918	42,964		7,965			2,229				1,292,762	32
33	Real Estate Taxes			5,357		234							5,591	33
34	Rent-Facility & Grounds		(1,800,000)	4,073									(1,795,927)	34
35	Rent-Equipment & Vehicles			1,351									1,351	35
36	Other (specify):*	(53,007)	53,007											36
37	TOTAL Ownership	(219,953)	2,858	69,095		9,282			11,941				(126,777)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(648)											(648)	43
44	TOTAL Special Cost Centers	(648)											(648)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(392,509)	123,108	(34,647)	206,952	44,683	(5,254)		(2,624)				(60,292)	45

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/08

Ending:

12/31/08

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	\$ 1,800,000	Rainbow Beach Real Estate	100.00%	\$	\$ (1,800,000)	1
2	V	32 Interest	870	Rainbow Beach Real Estate	100.00%	1,240,788	1,239,918	2
3	V	21 Filing Fee		Rainbow Beach Real Estate	100.00%	250	250	3
4	V	19 Consulting Fee		Rainbow Beach Real Estate	100.00%	120,000	120,000	4
5	V	30 Depreciation Expense		Rainbow Beach Real Estate	100.00%	509,933	509,933	5
6	V	36 Amortization Expense		Rainbow Beach Real Estate	100.00%	53,007	53,007	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,800,870			\$ 1,923,978	\$ * 123,108	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 # 0047332 Report Period Beginning: 01/01/08 Ending: 12/31/08

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. / Extended Care Consulting, LLC	100.00%	\$ 575	\$ 575	15	
16	V	02	Food		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	590	590	16	
17	V	03	Housekeeping		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	569	569	17	
18	V	05	Utilities		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	3,469	3,469	18	
19	V	06	Maintenance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,384	4,384	19	
20	V	17	Administrative		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,759	2,759	20	
21	V	19	Professional Fees	180,269	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	20,488	(159,781)	21	
22	V	20	Dues and Subscriptions		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	7,618	7,618	22	
23	V	21	Office and Clerical		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	33,231	33,231	23	
24	V	24	Seminar and Travel		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,951	1,951	24	
25	V	25	Other Staff Admin. Trans.		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,654	1,654	25	
26	V	26	Insurance		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,209	1,209	26	
27	V	30	Depreciation		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	15,350	15,350	27	
28	V	32	Interest		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	42,964	42,964	28	
29	V	33	Real Estate Taxes		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	5,357	5,357	29	
30	V	34	Rent - Building		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	4,073	4,073	30	
31	V	35	Rent - Equipment & Auto		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	1,351	1,351	31	
32	V	22	Employee Benefits	1,970	Care Centers, Inc. / Extended Care Consulting, LLC	100.00%		(1,970)	32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 182,239			\$ 147,592	\$ * (34,647)	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: 01/01/08Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Maintenance (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	8,463	\$ 8,463	15
16	V	06	Maintenance (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	2,681	2,681	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%			18
19	V	17	Administrative (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	10,280	10,280	19
20	V	21	Office and Clerical (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	160,086	160,086	20
21	V	21	Office and Clerical (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%			21
22	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%	25,442	25,442	22
23	V	27	Emp. Ben. - Gen. Admin. (Direct)		Care Centers, Inc. / Extended Care Consulting, LLC	100.00%			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		\$				\$ 206,952	\$ * 206,952	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: 01/01/08Ending: 12/31/08

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. / Extended Care Clinical, LLC	100.00%	\$ 63	\$ 63	15	
16	V	05	Utilities		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	145	145	16	
17	V	06	Maintenance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	18	18	17	
18	V	19	Professional Fees	116,477	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,657	(114,820)	18	
19	V	20	Dues and Subscriptions		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	10	10	19	
20	V	21	Office & Clerical		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	277	277	20	
21	V	24	Travel and Seminar		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	225	225	21	
22	V	26	Insurance		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	20	20	22	
23	V	30	Depreciation		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	1,083	1,083	23	
24	V	32	Interest		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	7,965	7,965	24	
25	V	33	Real Estate Taxes		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	234	234	25	
26	V	01	Dietary Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	4,224	4,224	26	
27	V	07	Emp. Ben. - Gen. Serv.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	548	548	27	
28	V	10	Nursing Salary	6,693	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	42,909	36,216	28	
29	V	10a	Rehab Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	3,098	3,098	29	
30	V	12	Social Service Salary	3,158	Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	21,053	17,895	30	
31	V	15	Emp. Ben. - Healthcare		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	8,433	8,433	31	
32	V	17	Administration Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	52,453	52,453	32	
33	V	21	Office Salary		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	17,539	17,539	33	
34	V	27	Emp. Ben. - Gen. Admin.		Care Centers Clinical, Inc. / Extended Care Clinical, LLC	100.00%	9,057	9,057	34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 126,328			\$ 171,011	\$ * 44,683	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	1 Dietary	\$	Xcel Supply, LLC	100.00%	\$		15
16	V	3 Housekeeping	23,108	Xcel Supply, LLC	100.00%	21,061	(2,047)	16
17	V	4 Laundry	3,436	Xcel Supply, LLC	100.00%	3,132	(304)	17
18	V	6 Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10 Nursing	30,169	Xcel Supply, LLC	100.00%	27,496	(2,672)	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	2,568	Xcel Supply, LLC	100.00%	2,340	(227)	24
25	V	24 Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	10 Ancillary	36	Xcel Supply, LLC	100.00%	33	(3)	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		\$ 59,317			\$ 54,063	\$ * (5,254)	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 36,577	\$ 36,577	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	36,577	CCS Employee Benefits Group	100.00%		(36,577)	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			\$ 36,577			\$ 36,577	\$ *	39

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

VII. RELATED PARTIES (continued)

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	4 Amount	Name of Related Organization					
15	V	06	Repairs	\$	Vent Lease, LLC.	100.00%	\$ 137	\$ 137	15
16	V	21	Office and Clerical		Vent Lease, LLC.	100.00%	15	15	16
17	V	25	Auto Expense / Travel		Vent Lease, LLC.	100.00%	1	1	17
18	V	26	Insurance		Vent Lease, LLC.	100.00%	3	3	18
19	V	30	Depreciation		Vent Lease, LLC.	100.00%	454	454	19
20	V	32	Interest		Vent Lease, LLC.	100.00%	77	77	20
21	V	30	Depreciation - Matrix		Vent Lease, LLC.	100.00%	9,258	9,258	21
22	V	32	Interest - Matrix		Vent Lease, LLC.	100.00%	2,152	2,152	22
23	V	21	Office and Clerical	13,571	Vent Lease, LLC.	100.00%		(13,571)	23
24	V	10	Ancillary	1,150	Vent Lease, LLC.	100.00%		(1,150)	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			\$ 14,721			\$ 12,097	\$ * (2,624)	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: 01/01/08

Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Shareholder	Administrative	51.00%	See Attached	1.39	3.01%	Mgmt. Fees	\$ 37,029	17-3	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.30	4.18%	Alloc. Salary	6,389	17-3	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	0.28	0.70%	Alloc. Salary	503	22-3	3
4	Kim Rudolph	Relative	Clerical	0.00%	See Attached	0.12	0.71%	Alloc. Salary	102	22-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 44,023		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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Inc/Extended Care Consulting LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V 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	1,635,146	31	\$ 13,778	\$ 68,390	\$ 575	1
2	02	Food	Patient Days	1,635,146	31	13,971	68,390	590	2
3	03	Housekeeping	Patient Days	1,635,146	31	13,659	68,390	569	3
4	05	Utilities	Patient Days	1,635,146	31	83,022	68,390	3,469	4
5	06	Maintenance	Patient Days	1,635,146	31	104,857	68,390	4,384	5
6	17	Administrative	Patient Days	1,635,146	31	66,000	68,390	2,759	6
7	19	Professional Fees	Patient Days	1,635,146	31	491,332	68,390	20,488	7
8	20	Dues and Subscriptions	Patient Days	1,635,146	31	182,607	68,390	7,618	8
9	21	Office and Clerical	Patient Days	1,635,146	31	797,040	68,390	33,231	9
10	24	Seminar and Travel	Patient Days	1,635,146	31	46,589	68,390	1,951	10
11	25	Other Staff Admin. Trans.	Patient Days	1,635,146	31	39,698	68,390	1,654	11
12	26	Insurance	Patient Days	1,635,146	31	28,827	68,390	1,209	12
13	30	Depreciation	Patient Days	1,635,146	31	505,348	68,390	15,350	13
14	32	Interest	Patient Days	1,635,146	31	1,031,834	68,390	42,964	14
15	33	Real Estate Taxes	Patient Days	1,635,146	31	128,276	68,390	5,357	15
16	34	Rent - Building	Patient Days	1,635,146	31	97,438	68,390	4,073	16
17	35	Rent - Equipment & Auto	Patient Days	1,635,146	31	32,530	68,390	1,351	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,676,806	\$	\$ 147,592	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Centers Inc/Extended Care Consulting LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	06	Maintenance (Pooled)	Patient Days	1,635,146	31	202,448	202,448	68,390	8,463	1
2	06	Maintenance (Direct)	Direct		31	422,013	422,013			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,635,146	31	63,663		68,390	2,681	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	53,015				4
5	17	Administrative (Pooled)	Patient Days	1,635,146	31	246,132	246,132	68,390	10,280	5
6	21	Office and Clerical (Pooled)	Patient Days	1,635,146	31	3,830,025	3,830,025	68,390	160,086	6
7	21	Office and Clerical (Direct)	Direct		31	695,305	695,305			7
8	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,635,146	31	608,507		68,390	25,442	8
9	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	90,171				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					\$ 6,211,280	\$ 5,395,924		\$ 206,952	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Care Center Clinical/Extended Care Clinical
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	03	Housekeeping	Patient Days	1,635,146	31	\$ 1,505	\$ 68,390	\$ 63	1
2	05	Utilities	Patient Days	1,635,146	31	3,449	68,390	145	2
3	06	Maintenance	Patient Days	1,635,146	31	431	68,390	18	3
4	19	Professional Fees	Patient Days	1,635,146	31	39,159	68,390	1,657	4
5	20	Dues and Subscriptions	Patient Days	1,635,146	31	244	68,390	10	5
6	21	Office & Clerical	Patient Days	1,635,146	31	6,594	68,390	277	6
7	24	Travel and Seminar	Patient Days	1,635,146	31	5,327	68,390	225	7
8	26	Insurance	Patient Days	1,635,146	31	465	68,390	20	8
9	30	Depreciation	Patient Days	1,635,146	31	25,565	68,390	1,083	9
10	32	Interest	Patient Days	1,635,146	31	191,164	68,390	7,965	10
11	33	Real Estate Taxes	Patient Days	1,635,146	31	5,595	68,390	234	11
12	01	Dietary Salary	Patient Days	1,635,146	31	101,177	101,177	4,224	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,635,146	31	13,096	68,390	548	13
14	10	Nursing Salary	Patient Days	1,635,146	31	867,390	867,390	36,216	14
15	10a	Rehab Salary	Patient Days	1,635,146	31	74,072	74,072	3,098	15
16	12	Social Service Salary	Patient Days	1,635,146	31	430,372	430,372	17,936	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,635,146	31	177,415	68,390	7,412	17
18	17	Administration Salary	Patient Days	1,635,146	31	1,257,059	1,257,059	52,453	18
19	21	Office Salary	Patient Days	1,635,146	31	420,417	420,417	17,539	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,635,146	31	216,825	68,390	9,057	20
21	10	Nursing Salary	Direct Allocation			401,447	401,447	6,693	21
22	12	Social Service Salary	Direct Allocation			61,016	61,016	3,117	22
23	15	Emp. Ben. - Healthcare	Direct Allocation			51,816		1,021	23
24									24
25	TOTALS					\$ 4,351,600	\$ 3,612,950	\$ 171,011	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		\$	1
2	3	Housekeeping	Direct Allocation					21,061	2
3	4	Laundry	Direct Allocation					3,132	3
4	6	Repairs & Maintenance	Direct Allocation						4
5	10	Nursing	Direct Allocation					27,496	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					2,340	10
11	24	Seminars & Education	Direct Allocation						11
12	10	Ancillary	Direct Allocation					33	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				\$	\$		\$ 54,063	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 Main Street
 City / State / Zip Code Evanston, Illinois 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		\$	\$		\$ 36,577	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				\$	\$		\$ 36,577	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	669,310	26	\$ 79,460	\$ 1,150	\$ 137	1
2	21	Office and Clerical	Direct Billing	669,310	26	8,933	1,150	15	2
3	25	Auto Expense / Travel	Direct Billing	669,310	26	473	1,150	1	3
4	26	Insurance	Direct Billing	669,310	26	1,630	1,150	3	4
5	30	Depreciation	Direct Billing	669,310	26	264,263	1,150	454	5
6	32	Interest	Direct Billing	669,310	26	44,568	1,150	77	6
7	30	Depreciation - Matrix	Patient Days	1,635,146	31	221,356	68,390	9,258	7
8	32	Interest - Matrix	Patient Days	1,635,146	31	51,456	68,390	2,152	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					\$ 672,138	\$	\$ 12,097	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

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: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

	1	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
6												6						
7	TOTAL Long-Term											7						
Working Capital																		
8	VGM Financial		X	Furniture			\$	\$ 53,549			\$	8						
9	Fox Valley											291						
10												10						
11												11						
12												12						
13												13						
14	TOTAL Working Capital											14						
B. Non-Facility Related*																		
15	Allocated from CC/EC Clinical		X				\$	\$			\$	7,965						
16	Allocated from Vent Lease		X									2,229						
17												17						
18												18						
19												19						
20	TOTAL Non-Facility Related											10,194						

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	217,153	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	210,196	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(6,957)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	214,835	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>3,826</u> For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	207,878	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2003	<u>185,455</u>	<u>8</u>	
	2004	<u>186,422</u>	<u>9</u>	
	2005	<u>188,321</u>	<u>10</u>	
	2006	<u>206,813</u>	<u>11</u>	
	2007	<u>204,605</u>	<u>12</u>	
2008 Accrual = \$204,605 x 1.05 = \$214,835				
Allocated from CC/EC - \$5,357 CCI/ECC, \$234 CC/EC Clinical				

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-30-112-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,136.78</u>	\$ <u>1,136.78</u>
2. <u>21-30-112-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>30,627.70</u>	\$ <u>30,627.70</u>
3. <u>21-30-112-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>34,430.38</u>	\$ <u>34,430.38</u>
4. <u>21-30-112-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>241.31</u>	\$ <u>241.31</u>
5. <u>21-30-112-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>241.31</u>	\$ <u>241.31</u>
6. <u>21-30-112-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>28,990.72</u>	\$ <u>28,990.72</u>
7. <u>21-30-112-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>36,713.29</u>	\$ <u>36,713.29</u>
8. <u>21-30-112-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>726.73</u>	\$ <u>726.73</u>
9. <u>21-30-112-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>731.27</u>	\$ <u>731.27</u>
10. <u>21-30-112-051-0000</u>	<u>Long Term Care Property</u>	\$ <u>65,127.40</u>	\$ <u>65,127.40</u>
	TOTALS	\$ <u>198,966.89</u>	\$ <u>198,966.89</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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>5,637.78</u>	\$ <u>5,637.78</u>
2. <u>See Attached</u>	<u>2201 Main, LLC Allocation</u>	\$ <u>122,122.75</u>	\$ <u>2,285.31</u>
3. <u>See Attached</u>	<u>Care Centers Building Allocation</u>	\$ <u>43,667.89</u>	\$ <u>1,217.08</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>171,428.42</u>	\$ <u>9,140.17</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:

01/01/08 Ending:

12/31/08

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>Allocated from CCI/ECC</u>			<u>16,713</u>	2
3	TOTALS			\$ 501,722	3

SEE ACCOUNTANTS' COMPILATION REPORT

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

0047332

Report Period Beginning:

01/01/08

Ending:

12/31/08

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
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67		9,549,625	509,933		244,853	(265,080)	979,412	67
68		93,126	4,922		4,922		32,102	68
69			103,057			(103,057)		69
70		\$ 9,642,751	\$ 617,912		\$ 249,775	\$ (368,137)	\$ 1,011,514	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:

01/01/08

Ending:

12/31/08

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,642,751	\$ 617,912		\$ 249,775	\$ (368,137)	\$ 1,011,514	1
2	Lectro-Loc Security System	2005	33,668		20	1,683	1,683	5,331	2
3	Elevator Pre-Maintenance	2005	6,000		20	300	300	950	3
4	Remodeling Down Payment	2006	32,800		20	1,640	1,640	4,920	4
5	Replace Existing Curcuits And Keys	2006	3,600		20	180	180	540	5
6	Remodeling Installment	2006	25,000		20	1,250	1,250	3,646	6
7	Freight Elevator Repair	2006	15,700		20	785	785	2,224	7
8	Install Vct Flooring	2006	3,450		20	173	173	489	8
9	Window Replacement	2006	33,250		20	1,663	1,663	4,710	9
10	Remodeling Installment	2006	25,000		20	1,250	1,250	3,438	10
11	New Water & Drain Connections	2006	3,048		20	152	152	419	11
12	Nurse Call System On 1St Floor	2006	26,000		20	1,300	1,300	3,575	12
13	Custom Built Laminated Cabinets	2006	8,108		20	405	405	1,115	13
14	Complete Violation Repairs	2006	7,531		20	377	377	941	14
15	Bathroom Leak Repair	2006	9,200		20	460	460	1,112	15
16	Basement Drainage System	2006	18,300		20	915	915	2,211	16
17	Fire Damper Replacement	2006	2,786		20	139	139	337	17
18	Nurse Call System Installment	2006	1,811		20	91	91	204	18
19	Install Aluminum Windows In Community Room	2006	6,334		20	317	317	686	19
20	Sewage Pump System	2006	5,240		20	262	262	546	20
21	Heating Coil Replacement	2006	6,738		20	1,348	1,348	4,043	21
22	Air Vent System Installation	2006	5,550		20	1,110	1,110	3,237	22
23	Boiler Expansion Tank Replacement	2006	3,706		20	741	741	2,162	23
24	Boiler Repairs	2006	3,951		20	790	790	2,305	24
25	Overhaul Hvac System	2006	28,500		20	1,425	1,425	3,681	25
26	Elevator Door And Fuse Replacement	2006	2,635		20	527	527	1,274	26
27	Elevator Cylinder Repair And Install	2006	53,200		20	10,640	10,640	25,713	27
28	Installed New Boxes For Call Lights	2006	6,728		20	1,346	1,346	2,803	28
29	Foundation Work - Repair On Drainage System	2007	31,230		20	1,562	1,562	2,993	29
30	Remodel - Shower Stalls	2007	32,400		20	1,620	1,620	2,430	30
31	Repair - Laundry Rm Leakage	2007	11,700		20	585	585	878	31
32	Catch Basin & Asphalt Repair	2007	2,782		20	139	139	197	32
33	Installation Of Fire Damper Actuators	2007	12,362		20	1,766	1,766	2,060	33
34	TOTAL (lines 1 thru 33)		\$ 10,111,059	\$ 617,912		\$ 286,716	\$ (331,196)	\$ 1,102,684	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,111,059	\$ 617,912		\$ 286,716	\$ (331,196)	\$ 1,102,684	1
2	New Boiler	2007	10,763		20	897	897	1,046	2
3	New Fire Alarm System	2007	29,789		20	4,256	4,256	4,965	3
4	Door Replacement	2008	5,785		20	289	289	289	4
5	Expansion Tank	2008	4,311		20	216	216	216	5
6	Replacing Boards And Parts On Elevator	2008	3,770		20	173	173	173	6
7	Replaced Parts For Elevator Due To Water Damage	2008	6,010		20	275	275	275	7
8	Adj #54 - Proceeds From Insurance	2008	(2,234)		20	(102)	(102)	(102)	8
9	Doors	2008	6,145		20	256	256	256	9
10	Steel Doors	2008	5,220		20	174	174	174	10
11	Water Heater	2008	11,588		20	1,545	1,545	1,545	11
12	Installation Of New Washer & Dryer	2008	2,000		20	233	233	233	12
13	Work On Elevator Shaft	2008	28,480		20	831	831	831	13
14	Elevator Installation	2008	111,525		20	3,253	3,253	3,253	14
15	New Laundry Rooms	2008	12,150		20	304	304	304	15
16	Elevator Repair	2008	15,000		20	313	313	313	16
17	Roof Repairs	2008	4,600		20	58	58	58	17
18	Replaced 2 Rooftop Hvac Units	2008	15,985		20	200	200	200	18
19	Elevator Pit Repairs	2008	20,000		20	167	167	167	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)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
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8									8
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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 12L, Carried Forward		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

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		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,401,946	\$ 617,912		\$ 300,054	\$ (317,858)	\$ 1,116,880	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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	211		2005	1960	\$ 9,549,625	\$	39	\$ 244,853	\$ 244,853	\$ 979,412	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Rainbow Beach Real Estate Depreciation					509,933					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:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	9,549,625	\$	509,933	\$	244,853	\$	244,853	\$	979,412	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:

01/01/08

Ending:

12/31/08

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		Allocated From CCI/Extended Care Consulting	2002	2002	\$ 18,514	\$ 475	39	\$ 475	\$	\$ 2,987	4
5		Allocated from CCI/ECC - CCI Building		1996	30,687	787	39	787		9,475	5
6		Allocated from EC/CC Clinical, Inc.	2002	2002	2,128	55	39	55		343	6
7											7
8											8
		Improvement Type**									
9		Allocated From CCI/Extended Care Consulting		2002	15,294	1,398	20	1,398		7,002	9
10		Allocated From CCI/Extended Care Consulting		2003	18,024	1,647	20	1,647		8,252	10
11		Allocated From CCI/Extended Care Consulting		2005	896	95	20	95		228	11
12		Allocated From CCI/Extended Care Consulting		2007	187	9	20	9		22	12
13											13
14		Allocated from CCI/ECC - CCI Building		1996	517	-	20	-		517	14
15		Allocated from CCI/ECC - CCI Building		1997	2,947	95	20	95		1,497	15
16											16
17		Allocated from EC/CC Clinical, Inc.		2002	1,758	161	20	161		805	17
18		Allocated from EC/CC Clinical, Inc.		2003	2,071	189	20	189		948	18
19		Allocated from EC/CC Clinical, Inc.		2005	103	11	20	11		26	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:

01/01/08

Ending:

12/31/08

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	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 93,126	\$ 4,922		\$ 4,922	\$	\$ 32,102	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: 01/01/08 Ending: 12/31/08

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	\$ 1,593,947	\$ 18,419	\$ 168,935	\$ 150,516	10	\$ 698,937	71
72	Current Year Purchases	16,487	12	722	710	10	722	72
73	Fully Depreciated Assets	3,243				10	3,243	73
74								74
75	TOTALS	\$ 1,613,677	\$ 18,431	\$ 169,657	\$ 151,226		\$ 702,902	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		Allocated from CCI/ECC	2008	\$ 35,162	\$ 2,185	\$ 2,185		5	\$ 30,230	76
77		Allocated from CC/EC Clinical	2008	3,048	609	609		5	1,185	77
78										78
79										79
80	TOTALS			\$ 38,210	\$ 2,794	\$ 2,794			\$ 31,415	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)		\$ 12,555,555	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 639,137	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 472,505	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (166,632)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 1,851,197	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	Allocated from CCI/ECC				4,073			5
6								6
7	TOTAL				\$ 4,073			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,629 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/08 Ending: 12/31/08 **XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/08

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 91,203	\$ 414,380	1
2	Cash-Patient Deposits	28,342	28,342	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,283,590	2,283,590	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	124,199	124,199	6
7	Other Prepaid Expenses	177,666	177,666	7
8	Accounts Receivable (owners or related parties)	400,000	500,000	8
9	Other(specify): <u> See Attached Schedule </u>	314,373	268,373	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,419,373	\$ 3,796,550	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		485,009	13
14	Buildings, at Historical Cost		9,549,265	14
15	Leasehold Improvements, at Historical Cost	667,306	1,996,229	15
16	Equipment, at Historical Cost	255,495	255,495	16
17	Accumulated Depreciation (book methods)	(212,090)	(2,629,937)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		69,197	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(29,759)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u> See Attached Schedule </u>	1,503,526	1,503,526	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,214,237	\$ 11,199,025	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,633,610	\$ 14,995,575	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 776,221	\$ 776,221	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,636	15,636	28
29	Short-Term Notes Payable	1,400,000	1,400,000	29
30	Accrued Salaries Payable	165,790	165,790	30
31	Accrued Taxes Payable (excluding real estate taxes)	43,145	43,145	31
32	Accrued Real Estate Taxes(Sch.IX-B)	214,835	214,835	32
33	Accrued Interest Payable		115,560	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u> See Attached Schedule </u>	1,542,698		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,158,325	\$ 2,731,187	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	53,549	53,549	39
40	Mortgage Payable		25,289,179	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u> See Attached Schedule </u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 53,549	\$ 25,342,728	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,211,874	\$ 28,073,915	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,421,736	\$ (13,078,340)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,633,610	\$ 14,995,575	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,270,653	1
2	Restatements (describe):		2
3	Replacement Tax	(30,046)	3
4	Prior Year Income Adjustment	46	4
5	Rounding	6	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,240,659	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,154,577	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	(973,500)	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)	\$ 181,077	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,421,736	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center# 0047332Report Period Beginning: 01/01/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,765,148	1
2	Discounts and Allowances for all Levels	(2,901)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,762,247	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	314	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 314	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	2,901	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,901	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	314	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 314	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	31,669	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 31,669	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,797,445	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,740,110	31
32	Health Care	2,063,396	32
33	General Administration	1,566,828	33
B. Capital Expense			
34	Ownership	2,156,046	34
C. Ancillary Expense			
35	Special Cost Centers	648	35
36	Provider Participation Fee	115,840	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,642,868	40
41	Income before Income Taxes (line 30 minus line 40)**	1,154,577	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,154,577	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: 01/01/08

Ending:

12/31/08

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	1,066	1,264	\$ 51,280	\$ 40.57	1
2	Assistant Director of Nursing	1,733	2,033	61,762	30.38	2
3	Registered Nurses	3,899	4,127	117,874	28.56	3
4	Licensed Practical Nurses	17,720	18,980	450,245	23.72	4
5	CNAs & Orderlies	71,702	75,987	733,608	9.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,656	1,805	22,517	12.47	9
10	Activity Assistants	9,142	9,876	104,833	10.61	10
11	Social Service Workers	21,088	23,019	369,614	16.06	11
12	Dietician	392	416	5,032	12.10	12
13	Food Service Supervisor	1,881	2,360	35,762	15.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,182	6,944	75,950	10.94	15
16	Dishwashers	18,239	19,691	179,240	9.10	16
17	Maintenance Workers	28,559	29,809	334,786	11.23	17
18	Housekeepers	23,795	25,276	223,380	8.84	18
19	Laundry	6,156	6,691	57,536	8.60	19
20	Administrator	1,947	2,309	119,550	51.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,496	8,176	105,712	12.93	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	1,824	2,067	18,873	9.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	9,714	9,788	50,180	5.13	33
34	TOTAL (lines 1 - 33)	234,191	250,618	\$ 3,117,734 *	\$ 12.44	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	201	\$ 9,051	01-03	35
36	Medical Director	Monthly	10,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,693	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	4	200	11-03	44
45	Social Service Consultant	46	2,538	12-03	45
46	Other(specify)				46
47	<u>See Attached - Care Centers Allocation</u>		6,693	10-03	47
48	<u>See Attached - Care Centers Allocation</u>		3,158	12-03	48
49	TOTAL (lines 35 - 48)	251	\$ 35,333		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	9	351	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9	\$ 351		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/08

Ending: 12/31/08

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Charles Hill-Jeon (01/01-09/19)	Administrator	0	\$ 89,012	Workers' Compensation Insurance	\$ 65,849	IDPH License Fee	\$ 1,045		
Blake A. Wiley (09/20-12/31)	Administrator	0	30,538	Unemployment Compensation Insurance	142,565	Advertising: Employee Recruitment	11,616		
				FICA Taxes	236,536	Health Care Worker Background Check			
				Employee Health Insurance	97,324	(Indicate # of checks performed <u>241</u>)	3,516		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Alliance for Living	7,596		
				City Payroll Taxes	4,857	IL Association of HC Facilities	3,798		
				Employee Physicals	975	IL Council on LTC	750		
				Pension Expense	28,648	Dues & Subscriptions	868		
				Other Employee Benefits	4,199	See Supplemental Schedule	8,824		
				Holiday Expense	3,853	Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)			
					\$ 119,550				
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 584,805		
Description				Amount					
Management Fees - Eric Rothner				\$ 37,029					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 37,029					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount	
Frost, Ruttenberg & Rothblatt	Accounting	\$ 11,082					Out-of-State Travel	\$	
ADP	Payroll Processing	9,370							
Paycor	Payroll Processing	1,050							
National Datacare Corp	Data Processing	2,757					In-State Travel		
Personnel Planners	Unemployment Consult.	3,035							
Prospect Resources	Natural Gas Procurement	1,300							
Pinnacle Consulting	Customer Satisfaction	1,038							
Moshe Calamaro & Associates	Structural Engineering	2,607					Seminar Expense	7,385	
Care Centers, Inc.	Home Office Expense	180,269					Allocated from CCI/ECC	1,951	
Care Centers Clinical	Home Office Expense	116,477					Allocated from CC/EC Clinical	225	
Rogers Healthcare	Psychiatric Management	42,998							
See Supplemental Schedule		6,848					Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				\$ 378,831			TOTAL (agree to Sch. V, line 24, col. 8)		\$ 9,561

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Facility Name & ID Number Rainbow Beach Care Center

Report Period Beginning: 01/01/08 Ending: 12/31/08

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 FY2005	6 FY2006	7 FY2007	8 FY2008	9 FY2009	10 FY2010	11 FY2011	12 FY2012	13 FY2013
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
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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. Alliance for Living \$12,660; ILCLTC \$750
- (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. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 115,840
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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln 14
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT