FOR BHF USE							

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0024984

Facility Name: Newton Rest Haven

Address: 300 S Scott Street, PO Box 360 (Number) — Newton (City) — 62448 (Zip Code)

County: Jasper

Telephone Number: (618) 783-2309 **Fax #** (618) 783-2732

HFS ID Number:

Date of Initial License for Current Owners: 1969

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code ______
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [X] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other ______
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other ______

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling Telephone Number: (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/2011 to 6/30/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	Karen Kinder
	(Title)	Administrator/Owner
Paid Preparer	(Signed)	Accountants Compilation Report Attached (Date)
	(Print Name and Title)	J. Terry Dooling Partner
	(Firm Name & Address)	C.J. Schlosser & Company, L.L.C. 233 E. Center Drive, Alton, Il 62002
	(Telephone)	(618)465-7717 Fax # (618)465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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

	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	82	Skilled (SNF)	82	30,012	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	82	TOTALS	82	30,012	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,160	6,164	1,892	15,216	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,160	6,164	1,892	15,216	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.70%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care and Outpatient Therapy

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/1969

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/19/1984 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 1,892

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2012 Fiscal Year: 6/30/2012

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	120,128	688	1,872	122,688		122,688		122,688			1
2	Food Purchase		152,735		152,735		152,735		152,735			2
3	Housekeeping	39,359	3,420		42,779		42,779		42,779			3
4	Laundry	29,925	1,401		31,326	(1,349)	29,977		29,977			4
5	Heat and Other Utilities			77,430	77,430		77,430	(3,567)	73,863			5
6	Maintenance	87,413		29,420	116,833		116,833		116,833			6
7	Other (specify):* Medical Waste			17,564	17,564		17,564		17,564			7
8	TOTAL General Services	276,825	158,244	126,286	561,355	(1,349)	560,006	(3,567)	556,439			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	638,543	46,914	1,124	686,581	1,349	687,930	(3,627)	684,303			10
10a	Therapy											10a
11	Activities	18,138	2,002	1,843	21,983		21,983	(809)	21,174			11
12	Social Services	21,029		1,843	22,872		22,872		22,872			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	677,710	48,916	16,810	743,436	1,349	744,785	(4,436)	740,349			16
	C. General Administration											
17	Administrative	48,228			48,228		48,228		48,228			17
18	Directors Fees											18
19	Professional Services			26,004	26,004		26,004		26,004			19
20	Dues, Fees, Subscriptions & Promotions			24,687	24,687	820	25,507	(14,467)	11,040			20
21	Clerical & General Office Expenses	60,106	14,548	19,843	94,497		94,497	(3,781)	90,716			21
22	Employee Benefits & Payroll Taxes			189,582	189,582		189,582	(9,225)	180,357			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,061	15,061	(820)	14,241	(11,761)	2,480			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,663	37,663		37,663		37,663			26
27	Other (specify):*											27
28	TOTAL General Administration	108,334	14,548	312,840	435,722		435,722	(39,234)	396,488			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,062,869	221,708	455,936	1,740,513		1,740,513	(47,237)	1,693,276			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 Newton Rest Haven #0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			12,151	12,151		12,151		12,151			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,747	2,747		2,747	(2,747)				32
33	Real Estate Taxes			23,908	23,908		23,908		23,908			33
34	Rent-Facility & Grounds			60,000	60,000		60,000	(60,000)				34
35	Rent-Equipment & Vehicles			159	159		159		159			35
36	Other (specify):* Income Taxes			10,543	10,543		10,543	(10,543)				36
37	TOTAL Ownership			109,508	109,508		109,508	(73,290)	36,218			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,494	201,331	266,825		266,825		266,825			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,423	91,423		91,423		91,423			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		65,494	292,754	358,248		358,248		358,248			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,062,869	287,202	858,198	2,208,269		2,208,269	(120,527)	2,087,742			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 Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$ (2,870)	10	$	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				9
10	Interest and Other Investment Income	(2,747)	32		10
11	Discounts, Allowances, Rebates & Refunds	(3,781)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,211)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(9,225)	22		15
16	Personal Expenses (Including Transportation)	(11,761)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(867)	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	(7,182)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,543)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,340)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (60,527)		$	30

BHF USE ONLY

48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(60,000)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (60,000)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (120,527)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Newton Rest Haven

ID# 0024984

Report Period Beginning: 7/01/2011

Ending: 6/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Elimiante PAC dues, including Lobbying portion	$ (2,217)	20	1
2	Eliminate 2013 IDPH License paid in 2012	(1,990)	20	2
3	Offset Cable Reimbursement	(3,567)	5	3
4	Offset activities supplies reimbursement	(809)	11	4
5	Offset payments for medical records copies	(757)	10	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				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**	(9,340)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,567)	0	0	0	0	0	0	0	0	0	0	(3,567)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,567)	0	0	0	0	0	0	0	0	0	0	(3,567)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,627)	0	0	0	0	0	0	0	0	0	0	(3,627)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(809)	0	0	0	0	0	0	0	0	0	0	(809)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,436)	0	0	0	0	0	0	0	0	0	0	(4,436)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(14,467)	0	0	0	0	0	0	0	0	0	0	(14,467)	20
21	Clerical & General Office Expenses	(3,781)	0	0	0	0	0	0	0	0	0	0	(3,781)	21
22	Employee Benefits & Payroll Taxes	(9,225)	0	0	0	0	0	0	0	0	0	0	(9,225)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(11,761)	0	0	0	0	0	0	0	0	0	0	(11,761)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(39,234)	0	0	0	0	0	0	0	0	0	0	(39,234)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(47,237)	0	0	0	0	0	0	0	0	0	0	(47,237)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,747)	0	0	0	0	0	0	0	0	0	0	(2,747)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(60,000)	0	0	0	0	0	0	0	0	0	(60,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(10,543)	0	0	0	0	0	0	0	0	0	0	(10,543)	36
37	**TOTAL Ownership**	(13,290)	(60,000)	0	0	0	0	0	0	0	0	0	(73,290)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(60,527)	(60,000)	0	0	0	0	0	0	0	0	0	(120,527)	45

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Karen Kinder	100					

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 Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Building Rent	$ 60,000	Karen Kinder	100.00%	$	$ (60,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 60,000			$	$ * (60,000)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Karen Kinder	Administrator	Administrator	100.00		40	100.00	Salary	$ 48,228	17, 1	1
2	Roger Kinder	Maintenance Supervi	Maintenance Supe	0.00		40	100.00	Salary	48,000	6, 1	2
3	Kathryn Augustyn	Clerical	Clerical	0.00		25	100.00	Salary	9,453	21, 1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 105,681		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 Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Schedule Not Applicable					$	$		$	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 Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Peoples State Bank		X		Various	10/24/11	$ 188,000	$ 162,000	10/20/12	5.2500	$ 942	1
2	Peoples State Bank		X		Various	10/8/10	150,000		1/10/15	5.2500	1,805	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8									Interest Income Offset		(2,747)	8
9	TOTAL Facility Related						$ 338,000	$ 162,000			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 338,000	$ 162,000			$	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2011 report.	$	34,700	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.)	$	23,108	2
3. Under or (over) accrual (line 2 minus line 1).	$	(11,592)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	$	35,500	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 $ 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.	$	23,908	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2007	21,535	8
2008	21,830	9
2009	22,786	10
2010	23,108	11
2011	23,649	12

Line 2 : 2010 Taxes paid

Line 4: Accrual is based on 2010 tax bill plus half estimated 2011 tax bill for 1/1/12 - 6/30/12

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2011	$		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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Newton Rest Haven COUNTY Jasper

FACILITY IDPH LICENSE NUMBER 0024984

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	90-13-06-106-008	S PT NW 1/4	$ 23,079.24	$ 23,079.24
2.	90-13-06-300-027	N PT N 1/2 SW 1/4	$ 252.52	$ 252.52
3.	90-13-06-106-006	1.15 AC S PT NW 1/4	$ 260.74	$ 260.74
4.	90-13-06-300-003	PT OF N 1/2 SW 1/4	$ 56.76	$ 56.76
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,649.26	$ 23,649.26

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? __________ YES X__________ NO

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,849 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (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 [X] NO

If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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		320,166	1969	$ 23,827	1
2					2
3	TOTALS	320,166		$ 23,827	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	82		1969	1969	$ 449,793	$	30	$	$	$ 449,793	4
5			1969	1969	255,492		30				5
6											6
7											7
8											8
	Improvement Type**										
9	Nurses Station			1974	1,040		10			1,040	9
10	Landscaping			1976	3,786		10			3,786	10
11	Driveway			1979	1,187		15			1,187	11
12	Alarm System			1983	2,100		15			2,100	12
13	Flooring, Roof, and Ceiling			1984	31,689		15-18			31,689	13
14	Insulation, Utility Building, and Flooring			1985	16,758		19			16,758	14
15	Dampers and Wallpaper			1986	6,251		5-19			6,251	15
16	Flooring & Sidewalks			1987	5,257	162	10-31	162		4,323	16
17	Wallpaper			1988	9,153	296	31	296		6,963	17
18	Wallpaper and Water Heaters			1990	8,366	269	31	269		5,825	18
19	Soffit			1991	3,012	97	31	97		2,040	19
20	Water Heaters			1995	1,870	60	31	60		1,030	20
21	Stove			1996	3,510	90	39	90		1,485	21
22	Hot Water Heater			1996	2,572	66	39	66		1,083	22
23	Concrete Sealing			1996	2,239	57	39	57		909	23
24	Boiler			1997	2,465	63	39	63		974	24
25	Painting			1997	1,788	46	39	46		692	25
26	Fixed Equipment			1998	4,188		5			4,188	26
27	Electrical Shut Off Box			2003	1,130	113	10	113		1,027	27
28	Painting			2002	979	98	10	98		955	28
29	Plastering			2002	7,560	756	10	756		7,434	29
30	Awning			2002	963	64	15	64		631	30
31	Gutters			2002	3,619	241	15	241		2,393	31
32	Phone System			2004	956	64	15	64		515	32
33	Fire Alarm System			2004	5,260	351	15	351		2,834	33
34	Landscaping			2006	1,146	57	5	57		1,146	34
35	Tile			2006	10,558	705	15	705		3,989	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 Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 844,687	$ 3,655		$ 3,655	$	$ 563,040	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 60,278	$ 6,935	$ 6,935	$		$ 37,893	71
72	Current Year Purchases	13,272	704	704			704	72
73	Fully Depreciated Assets	159,655	557	557			159,655	73
74								74
75	TOTALS	$ 233,205	$ 8,196	$ 8,196	$		$ 198,252	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Faculty Business	Ford E350 Van	2001	$ 15,080	$	$	$	5	$ 15,080	76
77	Faculty Business	Trailer	1985	560				5	560	77
78	Faculty Business	Shop Truck	1998	1,000				5	1,000	78
79	Faculty Business	2004 Dodge Dakota Quad Cab	2011	1,500	300	300		5	325	79
80	TOTALS			$ 18,140	$ 300	$ 300	$		$ 16,965	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)	$ 1,119,859	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,151	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 12,151	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 778,257	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	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: YES NO Terms: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ N/A Description: N/A
    (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	Schedule		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39, 3	hrs	$	4,800	$ 65,880	$	4,800	$ 65,880	1
2	Licensed Speech and Language Development Therapist	39, 3	hrs		2,712	30,510		2,712	30,510	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39, 3	hrs		8,848	91,446		8,848	91,446	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				65,494		65,494	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Labe Fees & X-Rays	39,3				13,495			13,495	12
13	Other (specify):									13
14	TOTAL			$	16,360	$ 201,331	$ 65,494	16,360	$ 266,825	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 Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,120	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	283,381		3
4	Supply Inventory (priced at)	23,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,664		6
7	Other Prepaid Expenses	29,457		7
8	Accounts Receivable (owners or related parties)	364,913		8
9	Other(specify): Employee Loans	1,289		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 720,824	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,827		13
14	Buildings, at Historical Cost	449,793		14
15	Leasehold Improvements, at Historical Cost	139,403		15
16	Equipment, at Historical Cost	251,345		16
17	Accumulated Depreciation (book methods)	(778,257)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 86,111	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 806,935	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,782	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,734		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 141,016	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	162,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 162,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 303,016	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 503,919	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 806,935	$	48

SEE ACCOUNTANTS' COMPILATION REPORT *(See instructions.)

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 484,405	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 484,405	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	39,514	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	(20,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 19,514	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)**	$ 503,919	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,886,219	1
2	Discounts and Allowances for all Levels	(823)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,885,396	3
	B. Ancillary Revenue		
4	Day Care	2,870	4
5	Other Care for Outpatients		5
6	Therapy	317,339	6
7	Oxygen	8,041	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 328,250	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,331	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,331	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,309	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,309	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Misc Income & Rebates/Refunds	24,497	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,497	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,247,783	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	561,355	31
32	Health Care	743,436	32
33	General Administration	435,722	33
	B. Capital Expense		
34	Ownership	109,508	34
	C. Ancillary Expense		
35	Special Cost Centers	266,825	35
36	Provider Participation Fee	91,423	36
	D. Other Expenses (specify):		
37	Line 34 Includes $10,543 Income Tax		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,208,269	40
41	**Income before Income Taxes (line 30 minus line 40)****	39,514	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 39,514	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 812,360	44
45	Private Pay - Net Inpatient Revenue	743,060	45
46	Medicare - Net Inpatient Revenue	354,534	46
47	Other-(specify) Patient Refunds	(23,735)	47
48	Other-(specify) Bad Debts	(823)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,885,396	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

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	1,892	2,098	$ 52,348	$ 24.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,099	6,342	122,681	19.34	3
4	Licensed Practical Nurses	10,463	11,308	183,420	16.22	4
5	CNAs & Orderlies	29,113	29,176	260,167	8.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,798	1,806	18,137	10.04	9
10	Activity Assistants					10
11	Social Service Workers	1,569	1,788	21,029	11.76	11
12	Dietician	12,985	13,635	120,128	8.81	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,528	3,713	87,413	23.54	17
18	Housekeepers	4,307	4,464	39,359	8.82	18
19	Laundry	3,489	3,562	29,925	8.40	19
20	Administrator	1,760	2,050	48,228	23.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,690	4,061	60,106	14.80	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	1,251	1,258	17,670	14.05	31
32	Other Health Care(specify)					32
33	Other(specify) Unit Assistants	254	254	2,258	8.89	33
34	TOTAL (lines 1 - 33)	82,198	85,515	$ 1,062,869 *	$ 12.43	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	48	$ 1,872	1,3	35
36	Medical Director	Contract	12,000	9,3	36
37	Medical Records Consultant	16	1,124	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,843	11,3	44
45	Social Service Consultant	24	1,844	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	112	$ 18,683		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number: Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2011 Ending: 6/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Kinder	Administrator	100	$ 48,228
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 48,228

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
LuAllen, Cearlock, Barth & Burnam	Accounting Fees	$ 6,600
Oldfield Law Group	Legal Fees	994
Automatic Data Processing	Payroll Service	10,865
C.J. Schlosser & Co., L.L.C.	Accounting Fees	7,545
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 26,004

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,819
Unemployment Compensation Insurance	19,074
FICA Taxes	80,806
Employee Health Insurance	29,152
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	4,096
Life Insurance	410
TOTAL (agree to Schedule V, line 22, col.8)	$ 180,357

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,238
Health Care Worker Background Check (Indicate # of checks performed 71)	1,420
Patient Background Checks	
Bank Service Charges	10
Dues & Subscriptions	4,198
Licenses & Fees	1,184
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,040

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	445
Seminar Expense	375
Books & Manuals	1,660
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,480

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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8													
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10													
11													
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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? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $3,113**

(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 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,349** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **45,018**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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? **N/A** 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. $ **0** 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. $ **0**

c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**

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? **Yes**

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

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. $ **0**

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

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

NEWTON REST HAVEN
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
6/30/2012

Miscellaneous Income	20.00
Prior Period Medicare Settlement	15,363.00
Admit Fee	200.00
W. Eyman Cell Phone Reimb.	44.69
Miscellaneous Rebates & Refunds	3,736.47
Medical records copies reimbursement	757.25
Activities Supplies reimbursement	808.71
Utilities-Cable	3,567.00
	24,497.12

Newton Rest Haven
Attachment to Sch. XVII
June 30, 2012

BOOK TO TAX NET INCOME RECONCILIATION

BOOK NET INCOME (LOSS)	$ 39,514.00
DEPRECIATION ADJUSTMENT	(4,345.00)
FEDERAL INCOME TAX EXPENSE - NON-DEDUCTIBLE	6,207.00
ROUNDING DIFFERENCE	5.00
TAX NET INCOME (LOSS), PER FEDERAL RETURN	$ 41,381.00

NEWTON REST HAVEN
RECLASSES
ATTACHMENT TO SCHEDULE V
6/30/2012

DESCRIPTION	LINE #	INCREASE (DECREASE)
DUES, FEES, SUBSCRIPTIONS, & PROMOTIONS	20	820
TRAVEL & SEMINAR	24	(820)
To Reclass IHCA dues to the proper line		
LAUNDRY	4	(1,349)
NURSING & MEDICAL RECORDS	10	1,349
To reclass non-disposable diapers to the proper line		

NEWTON RES
TRAVEL AND SEMI
ATTACHMENT TO SCH
6/30/2(

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY
Angela Gorell, Jamie Klingler, Paula Schoonover	MDS Coord., Care Plan Coord., Admin Asst.	11/17/2011	Effingham, IL

ST HAVEN
NAR SCHEDULE
IEDULE XIX PART G
012

TITLE OF SEMINAR	SPONSOR	COST
SNF PPS Final Rule & Other Medicare Challenges: An In Depth Look	Illinois Healthcare Association	375

Total Seminars	375
Total Seminar Lodging/Travel/Meals	0
Books and Manuals	1,660
Other Travel Expense <$100 each	445
Total Travel and Seminar, Line 24	2,480