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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0024984

Facility Name: Newton Rest Haven

Address: 300 S Scott St Bx 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	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 7/01/2012 to 6/30/2013 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: 7/01/2012 Ending: 6/30/2013

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 07/01/2012

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,805	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	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,228	4,659	1,665	12,552	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,228	4,659	1,665	12,552	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.33%

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 1,665

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: 6/30/2013 Fiscal Year: 6/30/2013

* 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: 7/01/2012 Ending: 6/30/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	102,180	970	1,728	104,878		104,878		104,878			1
2	Food Purchase		130,363		130,363		130,363		130,363			2
3	Housekeeping	52,172	5,636		57,808		57,808		57,808			3
4	Laundry	26,046			26,046		26,046		26,046			4
5	Heat and Other Utilities			72,104	72,104		72,104	(4,020)	68,084			5
6	Maintenance	87,004		28,788	115,792		115,792		115,792			6
7	Other (specify):* Waste Disposal			1,359	1,359		1,359		1,359			7
8	TOTAL General Services	267,402	136,969	103,979	508,350		508,350	(4,020)	504,330			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	522,773	43,148	1,224	567,145		567,145	(2,926)	564,219			10
10a	Therapy											10a
11	Activities	20,023	1,754	1,588	23,365		23,365	(20)	23,345			11
12	Social Services	18,756		1,588	20,344		20,344		20,344			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	561,552	44,902	16,400	622,854		622,854	(2,946)	619,908			16
	C. General Administration											
17	Administrative	48,002			48,002		48,002		48,002			17
18	Directors Fees											18
19	Professional Services			27,625	27,625		27,625		27,625			19
20	Dues, Fees, Subscriptions & Promotions			18,496	18,496		18,496	(9,448)	9,048			20
21	Clerical & General Office Expenses	71,137	12,025	21,457	104,619		104,619	(116)	104,503			21
22	Employee Benefits & Payroll Taxes			187,053	187,053		187,053	(2,474)	184,579			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,456	12,456		12,456	(10,815)	1,641			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			25,614	25,614		25,614		25,614			26
27	Other (specify):*											27
28	TOTAL General Administration	119,139	12,025	292,701	423,865		423,865	(22,853)	401,012			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	948,093	193,896	413,080	1,555,069		1,555,069	(29,819)	1,525,250			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: 7/01/2012 Ending: 6/30/2013

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			10,745	10,745		10,745		10,745			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,961	22,961		22,961	(17,645)	5,316			32
33	Real Estate Taxes			25,189	25,189		25,189		25,189			33
34	Rent-Facility & Grounds			50,000	50,000		50,000	(50,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			108,895	108,895		108,895	(67,645)	41,250			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,294	295,565	345,859		345,859		345,859			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			116,231	116,231		116,231		116,231			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		50,294	411,796	462,090		462,090		462,090			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	948,093	244,190	933,771	2,126,054		2,126,054	(97,464)	2,028,590			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: 7/01/2012 Ending: 6/30/2013

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	$ (2,830)	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	(17,645)	32		10
11	Discounts, Allowances, Rebates & Refunds	(97)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,667)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(2,330)	22		15
16	Personal Expenses (Including Transportation)	(10,815)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(274)	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	(6,711)	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	(5,095)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (47,464)		$	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)	(50,000)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (50,000)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (97,464)		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

Newton Rest Haven

ID# 0024984

Report Period Beginning: 7/01/2012

Ending: 6/30/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate PAC Dues, inlcuding Lobbying Portion	$ (2,121)	20	1
2	Add back 2013 IDPH License paid in 2012	1,990	20	2
3	Offset Cable Reimbursement	(4,020)	5	3
4	Offset activites reimbursement	(20)	11	4
5	Offset Medical supplies rebate	(96)	10	5
6	Offset reimbursement for EE T-Shirts	(144)	22	6
7	Offset postage refund	(19)	21	7
8	Offset donations received for employee benefit	(665)	20	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**	(5,095)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

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	(4,020)	0	0	0	0	0	0	0	0	0	0	(4,020)	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	(4,020)	0	0	0	0	0	0	0	0	0	0	(4,020)	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	(2,926)	0	0	0	0	0	0	0	0	0	0	(2,926)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(20)	0	0	0	0	0	0	0	0	0	0	(20)	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	(2,946)	0	0	0	0	0	0	0	0	0	0	(2,946)	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	(9,448)	0	0	0	0	0	0	0	0	0	0	(9,448)	20
21	Clerical & General Office Expenses	(116)	0	0	0	0	0	0	0	0	0	0	(116)	21
22	Employee Benefits & Payroll Taxes	(2,474)	0	0	0	0	0	0	0	0	0	0	(2,474)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(10,815)	0	0	0	0	0	0	0	0	0	0	(10,815)	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	(22,853)	0	0	0	0	0	0	0	0	0	0	(22,853)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(29,819)	0	0	0	0	0	0	0	0	0	0	(29,819)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newton Rest Haven # 0024984 **Report Period Beginning:** 7/01/2012 **Ending:** 6/30/2013

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(17,645)	0	0	0	0	0	0	0	0	0	0	(17,645)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(50,000)	0	0	0	0	0	0	0	0	0	(50,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(17,645)	(50,000)	0	0	0	0	0	0	0	0	0	(67,645)	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)**	(47,464)	(50,000)	0	0	0	0	0	0	0	0	0	(97,464)	45

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

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. [X] YES [ ] NO

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

1 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	$ 50,000	Karen Kinder	100.00%	$	$ (50,000)	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			$ 50,000			$	$ * (50,000)	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: 7/01/2012 Ending: 6/30/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	Karen Kinder	Administrator	Administrator	100.00		40	100.00	Salary	$ 48,002	17,1	1
2	Roger Kinder	Maintenance Supervi	Maintenance Supe	0.00		40	100.00	Salary	48,000	6,1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 96,002		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: 7/01/2012 Ending: 6/30/2013

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 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: 7/01/2012 Ending: 6/30/2013

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Peoples State Bank		x		Various	10/23/12	$ 290,000	$ 280,000	10/20/13	5.2500	$ 22,161	1
2	Peoples State Bank		x	Line of Credit	Various	11/20/12	100,000	1	11/20/13	5.2500	800	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8									Interest Income Offset		(17,645)	8
9	TOTAL Facility Related						$ 390,000	$ 280,001			$ 5,316	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 390,000	$ 280,001			$ 5,316	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: 7/01/2012 Ending: 6/30/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 35,500	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.)		$ 23,689	2
3. Under or (over) accrual (line 2 minus line 1).		$ (11,811)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 37,000	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.		$ 25,189	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	21,830	8
	2009	22,786	9
	2010	23,108	10
	2011	23,649	11
	2012	24,672	12

Line 2: 2011 taxes Paid

Line 4: Accrual based on 2011 tax bill plus half estimated 2012 tax bill for 1/1/13 - 6/30/13

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Newton Rest Haven COUNTY Jasper

FACILITY IDPH LICENSE NUMBER 0024984

CONTACT PERSON REGARDING THIS REPORT Karen Kinder

TELEPHONE 618-783-2309 FAX #: 618-783-2732

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	90-13-16-106-008	S PT NW 1/4	$ 24,060.94	$ 24,060.94
2.	90-13-06-300-027	N PT N 1/2 SW 1/4	$ 270.50	$ 270.50
3.	90-13-06-106-006	1.15 AC S PT NW 1/4	$ 279.50	$ 279.50
4.	90-13-06-300-03	PT OF N 1/2 SW 1/4	$ 60.88	$ 60.88
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,671.82	$ 24,671.82

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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: 7/01/2012 Ending: 6/30/2013

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 Use	2 Square Feet	3 Year Acquired	4 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: 7/01/2012 Ending: 6/30/2013

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			1969	1969	$ 449,793	$		$	$	$ 449,793	4
5			1969	1969	255,492						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	Alarm System			1983	2,100		15			2,100	11
12	Flooring, Roof, and Ceiling			1984	31,689		15-18			31,689	12
13	Insulation, Utility Building, and Flooring			1985	16,758		19			16,758	13
14	Dampers and Wallpaper			1986	6,251		5-19			6,251	14
15	Sidewalks			1987	220		10			220	15
16	Wallpaper			1988	9,153	295	31	295		7,259	16
17	Wallpaper and Water Heaters			1990	8,366	270	31	270		6,095	17
18	Soffit			1991	3,012	97	31	97		2,138	18
19	Stove			1996	3,510	90	39	90		1,575	19
20	Concrete Sealing			1996	2,239	57	39	57		966	20
21	Boiler			1997	2,465	63	39	63		1,038	21
22	Painting			1997	1,788	46	39	46		737	22
23	Fixed Equipment			1998	4,188		5			4,188	23
24	Electrical Shut Off Box			2003	1,130	104	10	104		1,130	24
25	Painting			2002	979	25	10	25		979	25
26	Plastering			2002	7,560	126	10	126		7,560	26
27	Awning			2002	963	64	15	64		695	27
28	Gutters			2002	3,620	241	15	241		2,634	28
29	Phone System			2004	956	64	15	64		579	29
30	Fire Alarm System			2004	5,260	351	15	351		3,185	30
31	Landscaping			2006	1,146		5			1,146	31
32	Tile			2006	10,558	704	15	704		4,693	32
33	Install Fire Sprinkler System			2013	84,325	351	40	351		351	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 Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

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)		$ 918,347	$ 2,948		$ 2,948	$	$ 558,585	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: 7/01/2012 Ending: 6/30/2013

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	$ 59,969	$ 6,893	$ 6,893	$	5-15	$ 34,788	71
72	Current Year Purchases	9,278	592	592		10	592	72
73	Fully Depreciated Assets	137,852	162	162		5-10	137,852	73
74								74
75	TOTALS	$ 207,099	$ 7,647	$ 7,647	$		$ 173,232	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	Trailer	1985	$ 560	$	$	$	5	$ 560	76
77	Faculty Business	2004 Dodge Dakota Quad Cab	2011		150	150				77
78										78
79										79
80	TOTALS			$ 560	$ 150	$ 150	$		$ 560	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)	$ 1,149,833	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 10,745	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 10,745	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)	$ 732,377	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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

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.	/2014	$
13.	/2015	$
14.	/2016	$

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			$	$	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: 7/01/2012 Ending: 6/30/2013

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

STATE OF ILLINOIS

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				50,294		50,294	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Attached schedule				15,749	295,466	99	15,749	295,565	12
13	Other (specify):									13
14	TOTAL			$	15,749	$ 295,466	$ 50,393	15,749	$ 345,859	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:** 7/01/2012 **Ending:** 6/30/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2013 **(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	$ (6,932)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	238,912		3
4	Supply Inventory (priced at)	23,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	13,387		6
7	Other Prepaid Expenses	15,664		7
8	Accounts Receivable (owners or related parties)	361,170		8
9	Other(specify): Employee Loans	200		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 645,401	$	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	213,062		15
16	Equipment, at Historical Cost	207,659		16
17	Accumulated Depreciation (book methods)	(732,377)		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)**	$ 161,964	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 807,365	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 50,847	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1		29
30	Accrued Salaries Payable	57,376		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,000		32
33	Accrued Interest Payable	1,957		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)**	$ 147,181	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	280,000		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)**	$ 280,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 427,181	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 380,184	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 807,365	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 503,919	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 503,919	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(92,235)	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	(31,500)	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)**	$ (123,735)	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)**	$ 380,184	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

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	$ 1,403,161	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,403,161	3
	B. Ancillary Revenue		
4	Day Care	2,830	4
5	Other Care for Outpatients		5
6	Therapy	540,352	6
7	Oxygen	3,383	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 546,565	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	3,784	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,784	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,645	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,645	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income & Rebates/Refunds	58,584	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 58,584	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,029,739	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	508,350	31
32	Health Care	622,854	32
33	General Administration	423,865	33
	B. Capital Expense		
34	Ownership	108,895	34
	C. Ancillary Expense		
35	Special Cost Centers	462,090	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,126,054	40
41	**Income before Income Taxes (line 30 minus line 40)****	(96,315)	41
42	**Income Taxes**	4,080	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (92,235)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 660,641	44
45	Private Pay - Net Inpatient Revenue	609,041	45
46	Medicare - Net Inpatient Revenue	151,172	46
47	Other-(specify) Pateint Refunds	(17,693)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,403,161	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: 7/01/2012 Ending: 6/30/2013

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,095	$ 52,002	$ 24.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,985	5,065	96,459	19.04	3
4	Licensed Practical Nurses	8,908	9,240	159,417	17.25	4
5	CNAs & Orderlies	23,028	23,028	204,558	8.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,980	1,980	20,023	10.11	9
10	Activity Assistants					10
11	Social Service Workers	1,384	1,596	18,756	11.75	11
12	Dietician	11,456	11,745	102,180	8.70	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,458	4,196	87,004	20.73	17
18	Housekeepers	5,766	5,987	52,172	8.71	18
19	Laundry	3,035	3,095	26,046	8.42	19
20	Administrator	1,655	2,095	48,002	22.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,038	4,474	71,137	15.90	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	639	639	10,229	16.01	31
32	Other Health Care(specify)					32
33	Other(specify) Unit Assistants	13	13	108	8.31	33
34	TOTAL (lines 1 - 33)	72,265	75,248	$ 948,093 *	$ 12.60	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	48	$ 1,728	1,3	35
36	Medical Director	Contract	12,000	9,3	36
37	Medical Records Consultant	16	1,023	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	201	10,3	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	1,588	11,3	44
45	Social Service Consultant	24	1,588	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	112	$ 18,128		49

C. CONTRACT NURSES

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

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Kinder	Administrator	100	$ 48,002
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 48,002

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
Oldfield Law Group	Legal Fees	$ 2,703
Automated Data Processing	Payroll Service	10,697
Luallen, Cearlock, Barth, & Burnam	Accounting Fees	6,600
C.J. Schlosser & Co., L.L.C.	Accounting Fees	7,625
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 27,625

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,140
Unemployment Compensation Insurance	18,631
FICA Taxes	72,386
Employee Health Insurance	29,685
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	4,191
Employee Life Insurance	546
TOTAL (agree to Schedule V, line 22, col.8)	$ 184,579

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	1,651
Health Care Worker Background Check	
(Indicate # of checks performed 59)	1,180
Patient Background Checks	
Bank Service Charges	5
Dues & Subscriptions	3,298
Licenses & Fees	924
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,048

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	378
Seminar Expense	1,263
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,641

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2012 Ending: 6/30/2013

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 - $2,799**

(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. $ **160** 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. $ **116,231**
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 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

Attachment to Schedule XIV

6/30/2013

		1	2	3	4	5	6	7	8
			Staff		Outside Practitioner (other Than Consultant)		Supplies (Actual or Allocated)	Total Units (Col 2 + 4)	Total Cost (Col 3 + 5 +6)
Line #	Service	Schuler V Line & Column Reference	Units of Service	Cost	Units of Service	Cost	Cost		
12	Other:								
	Licensed Occupational Therapist	39,8			5,000	92,407		5,000	92,407
	Licensed Speech Therapist	39,8			2,823	53,506		2,823	53,506
	Licensed Physical Therapist	39,8			7,926	142,080	99	7,926	142,179
	X-Ray	39,3				4,406		-	4,406
	Laboratory	39,3				3,067		-	3,067
	Specialty Mattresses/Overlays	39,3						-	-
	Total to Schedule XIV, Line 12		-	-	15,749	295,466	99	15,749	295,565

Newton Rest Haven
Attachment to Sch. XVII
June 30, 2013

BOOK TO TAX NET INCOME RECONCILIATION

BOOK NET INCOME (LOSS)	$ (92,235.00)
DEPRECIATION ADJUSTMENT	2,397.00
FORM 4797 BOOK/TAX DIFFERENCE	3,195.00
CHARITABLE CONTRIBUTIONS	939.00
ROUNDING DIFFERENCE	4.00
TAX NET INCOME (LOSS), PER FEDERAL RETURN	$ (85,700.00)

NEWTON REST HAVEN
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
6/30/2013

Prior Period Medicare Settlement	48,878.00
Admit Fee	150.00
Miscellaneous Rebates & Refunds	96.87
Postage	18.77
Donations for employee benefit	665.00
Activities Supplies donation	20.00
Utilities-Cable	4,020.00
Employee Uniform Reimb.	143.57
McKesson Rebate (med supplies)	96.39
Gain on sale of fixed assets	4,495.85
	58,584.45