

Facility Name & ID Number Newton Rest Haven

0024984 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,180	4,187	2,004	12,371	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,180	4,187	2,004	12,371	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.46%

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

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

YES NO

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

Date started 08/01/1969

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

YES Date 11/19/1984 NO

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

YES NO If YES, enter number of beds certified 16 and days of care provided 2,004

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2014 Fiscal Year: 6/30/2014

* 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: 07/01/2013 Ending: 06/30/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	111,511	876	1,728	114,115		114,115		114,115		1
2	Food Purchase		122,743		122,743		122,743		122,743		2
3	Housekeeping	43,746	6,288		50,034		50,034		50,034		3
4	Laundry	24,745	974		25,719	(364)	25,355		25,355		4
5	Heat and Other Utilities			64,642	64,642		64,642	(4,080)	60,562		5
6	Maintenance	86,935		23,892	110,827		110,827		110,827		6
7	Other (specify):* Waste Disposal			1,409	1,409		1,409		1,409		7
8	TOTAL General Services	266,937	130,881	91,671	489,489	(364)	489,125	(4,080)	485,045		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	536,300	41,367	2,620	580,287	364	580,651	(2,701)	577,950		10
10a	Therapy										10a
11	Activities	15,012	1,850	1,763	18,625		18,625		18,625		11
12	Social Services	18,816		1,763	20,579		20,579		20,579		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	570,128	43,217	18,146	631,491	364	631,855	(2,701)	629,154		16
	C. General Administration										
17	Administrative	47,964			47,964		47,964		47,964		17
18	Directors Fees										18
19	Professional Services			28,027	28,027		28,027		28,027		19
20	Dues, Fees, Subscriptions & Promotions			20,641	20,641		20,641	(12,972)	7,669		20
21	Clerical & General Office Expenses	54,738	14,722	27,905	97,365		97,365	(213)	97,152		21
22	Employee Benefits & Payroll Taxes			190,830	190,830		190,830	(3,278)	187,552		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,070	10,070		10,070	(8,999)	1,071		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			55,862	55,862		55,862		55,862		26
27	Other (specify):*										27
28	TOTAL General Administration	102,702	14,722	333,335	450,759		450,759	(25,462)	425,297		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	939,767	188,820	443,152	1,571,739		1,571,739	(32,243)	1,539,496		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:

07/01/2013

Ending:

06/30/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			12,124	12,124		12,124	(348)	11,776			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,306	18,306		18,306	(9,265)	9,041			32
33	Real Estate Taxes			25,640	25,640		25,640	(52)	25,588			33
34	Rent-Facility & Grounds			45,000	45,000		45,000	(45,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			101,070	101,070		101,070	(54,665)	46,405			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,589	229,207	274,796		274,796		274,796			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			99,682	99,682		99,682		99,682			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		45,589	328,889	374,478		374,478		374,478			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	939,767	234,409	873,111	2,047,287		2,047,287	(86,908)	1,960,379			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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (2,691)	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	(9,265)	32		10
11	Discounts, Allowances, Rebates & Refunds	(206)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,480)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(2,706)	22		15
16	Personal Expenses (Including Transportation)	(8,999)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(285)	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	(7,446)	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	(8,830)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,908)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,000)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (45,000)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (86,908)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Newton Rest Haven

ID# 0024984

Report Period Beginning: 07/01/2013

Ending: 06/30/2014

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Eliminate PAC Dues, including Lobbying Portion	\$ (1,771)	20	1
2	Eliminate 1/2 of 2 yr. IDPH License paid in 2014	(1,990)	20	2
3	Offset Cable Reimbursement	(4,080)	5	3
4	Offset reimb. For copies of medical records	(10)	10	4
5	Offset postage refund	(7)	21	5
6	Offset EE life ins. Reimb.	(152)	22	6
7	Offset EE loan repayment	(420)	22	7
8	Adj. depr exp for diff in mdcd vs book F/A's	(348)	30	8
9	Eliminate real estate taxes paid in error	(52)	33	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	(8,830)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newton Rest Haven# 0024984

Report Period Beginning:

07/01/2013

Ending:

06/30/2014

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(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	(4,080)	0	0	0	0	0	0	0	0	0	0	(4,080)	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	(4,080)	0	0	0	0	0	0	0	0	0	0	(4,080)	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	(2,701)	0	0	0	0	0	0	0	0	0	0	(2,701)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	(2,701)	0	0	0	0	0	0	0	0	0	0	(2,701)	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	(12,972)	0	0	0	0	0	0	0	0	0	0	(12,972)	20
21	Clerical & General Office Expenses	(213)	0	0	0	0	0	0	0	0	0	0	(213)	21
22	Employee Benefits & Payroll Taxes	(3,278)	0	0	0	0	0	0	0	0	0	0	(3,278)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,999)	0	0	0	0	0	0	0	0	0	0	(8,999)	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	(25,462)	0	0	0	0	0	0	0	0	0	0	(25,462)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(32,243)	0	0	0	0	0	0	0	0	0	0	(32,243)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newton Rest Haven# 0024984

Report Period Beginning:

07/01/2013 Ending:06/30/2014

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(348)	0	0	0	0	0	0	0	0	0	0	(348)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,265)	0	0	0	0	0	0	0	0	0	0	(9,265)	32
33	Real Estate Taxes	(52)	0	0	0	0	0	0	0	0	0	0	(52)	33
34	Rent-Facility & Grounds	0	(45,000)	0	0	0	0	0	0	0	0	0	(45,000)	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	(9,665)	(45,000)	0	0	0	0	0	0	0	0	0	(54,665)	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)	(41,908)	(45,000)	0	0	0	0	0	0	0	0	0	(86,908)	45

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Building Rent	\$ 45,000	Karen Kinder	100.00%	\$	\$	(45,000) 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		\$ 45,000			\$	\$ *	(45,000) 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:

07/01/2013

Ending:

06/30/2014

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:

07/01/2013

Ending:

06/30/2014

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Karen Kinder	Administrator	Administrator	100.00		40	100.00	Salary	\$ 47,964	17,1	1
2	Roger Kinder	Maintenance Supervi	Maintenance Super	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	\$ 95,964		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:

07/01/2013

Ending: 6/30/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	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:

07/01/2013

Ending:

06/30/2014

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	Line of Credit	Various	3/3/05	\$ 150,000	\$ 285,000	5/3/15	5.2500	\$ 15,697	1								
2	Peoples State Bank		X	Line of Credit	Various	2/7/14	50,000		3/28/14	5.2500	129	2								
3	Peoples State Bank		X	Line of Credit	Various	11/20/12	100,000	1	5/3/14	5.2500	2,480	3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8									Interest Income Offset		(9,265)	8								
9	TOTAL Facility Related						\$ 300,000	\$ 285,001			\$ 9,041	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 300,000	\$ 285,001			\$ 9,041	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1. Real Estate Tax accrual used on 2013 report.				\$	37,000	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.)				\$	24,288	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	(12,712)	3	
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	38,300	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.				\$	25,588	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2009	22,786	8	FOR BHF USE ONLY			
	2010	23,108	9	13	FROM R. E. TAX STATEMENT FOR 2013	\$	13
	2011	23,649	10	14	PLUS APPEAL COST FROM LINE 5	\$	14
	2012	24,672	11	15	LESS REFUND FROM LINE 6	\$	15
	2013	25,507	12	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
Line 2: 2012 Taxes Paid							
Line 4: Accrual based on 2012 tax bill plus half estimated 2013 tax bill for 1/1/14-6/30/14							

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

2013 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 2013 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 2013.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>90-13-06-106-008</u>	<u>S PT NW 1/4 S6 T6 R10 5AC</u>	\$ <u>25,179.32</u>	\$ <u>25,179.32</u>
2. <u>90-13-06-300-027</u>	<u>N PT N 1/2 SW 1/4 S6 T6 R10 97AC</u>	\$ <u>43.96</u>	\$ <u>43.96</u>
3. <u>90-13-06-106-006</u>	<u>1.15 AC S PT NW 1/4 S6 T6 R10 1.1:</u>	\$ <u>284.02</u>	\$ <u>284.02</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>25,507.30</u></u>	\$ <u><u>25,507.30</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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:

07/01/2013 Ending:

06/30/2014

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: 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		<u>320,166</u>	<u>1969</u>	<u>\$ 23,827</u>	1
2					2
3	TOTALS	<u>320,166</u>		<u>\$ 23,827</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1969	1969	\$ 449,793	\$		\$	\$	\$ 449,793
5		1969	1969	255,492					
6									
7									
8									
	Improvement Type**								
9	Nurses Station		1974	1,040		10			1,040
10	Landscaping		1976	3,786		10			3,786
11	Alarm System		1983	2,100		15			2,100
12	Flooring, Roof, and Ceiling		1984	31,689		15-18			31,689
13	Insulation, Utility Building, and Flooring		1985	16,758		19			16,758
14	Dampers and Wallpaper		1986	6,251		5-19			6,251
15	Sidewalks		1987	220		10			220
16	Wallpaper		1988	9,153	295	31	295		7,554
17	Wallpaper and Water Heaters		1990	8,366	270	31	270		6,364
18	Soffit		1991	3,012	97	31	97		2,235
19	Stove		1996	3,510	90	39	90		1,665
20	Concrete Sealing		1996	2,239	57	39	57		1,024
21	Boiler		1997		63	39		(63)	
22	Painting		1997	1,788	46	39	46		783
23	Electrical Shut Off Box		2003	1,130		10			1,130
24	Painting		2002	979		10			979
25	Plastering		2002	7,560		10			7,560
26	Awning		2002	963	64	15	64		759
27	Gutters		2002	3,620	241	15	241		2,876
28	Phone System		2004	956	64	15	64		643
29	Fire Alarm System		2004	5,260	351	15	351		3,536
30	Tile		2006	8,342	704	15	556	(148)	3,180
31	Install Fire Sprinkler System		2013	84,325	2,108	40	2,108		2,460
32	Boiler		2014	2,500	241	10	104	(137)	104
33									
34									
35									
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:

07/01/2013 Ending: **06/30/2014**

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$ 910,832		\$ 4,343	\$ (348)	\$ 554,489	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:

07/01/2013

Ending:

06/30/2014

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	\$ 57,382	\$ 6,272	\$ 6,272	\$	5-15	\$ 30,897	71
72	Current Year Purchases	3,929	51	51		10	51	72
73	Fully Depreciated Assets	148,176	1,110	1,110		5-10	148,176	73
74								74
75	TOTALS	\$ 209,487	\$ 7,433	\$ 7,433	\$		\$ 179,124	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,144,146	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,124	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,776	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (348)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 733,613	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

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

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.	_____ /2015	\$ _____
13.	_____ /2016	\$ _____
14.	_____ /2017	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

16. Rental Amount for movable equipment: \$ N/A Description: N/A YES NO

(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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescripts				45,589		45,589	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>See attached schedule</u>				11,464	229,117	90	11,464	229,207	12
13	Other (specify):									13
14	TOTAL			\$	11,464	\$ 229,117	\$ 45,679	11,464	\$ 274,796	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/2014**

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,321	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	321,600		3
4	Supply Inventory (priced at)	23,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,162		6
7	Other Prepaid Expenses	7,664		7
8	Accounts Receivable (owners or related parties)	331,632		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 698,379	\$	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	215,277		16
17	Accumulated Depreciation (book methods)	(742,400)		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)	\$ 159,559	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 857,938	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 47,372	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1		29
30	Accrued Salaries Payable	59,275		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,300		32
33	Accrued Interest Payable	2,496		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)	\$ 147,444	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	285,000		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)	\$ 285,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 432,444	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 425,494	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 857,938	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 380,184	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 380,184	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	45,310	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	()	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)	\$ 45,310	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)	\$ 425,494	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven# 0024984Report Period Beginning: 07/01/2013Ending: 06/30/2014**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required**

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,575,112	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,575,112	3
B. Ancillary Revenue			
4	Day Care	2,691	4
5	Other Care for Outpatients		5
6	Therapy	455,980	6
7	Oxygen	323	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 458,994	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	5,407	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,407	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,265	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,265	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income & Reabtes/Refunds	43,819	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 43,819	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,092,597	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	489,489	31
32	Health Care	631,491	32
33	General Administration	450,759	33
B. Capital Expense			
34	Ownership	101,070	34
C. Ancillary Expense			
35	Special Cost Centers	274,796	35
36	Provider Participation Fee	99,682	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,047,287	40
41	Income before Income Taxes (line 30 minus line 40)**	45,310	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 45,310	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 713,696	44
45	Private Pay - Net Inpatient Revenue	560,150	45
46	Medicare - Net Inpatient Revenue	303,424	46
47	Other-(specify) Patient Refunds	(2,158)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,575,112	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: 07/01/2013

Ending: 06/30/2014

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	1,763	2,086	\$ 52,827	\$ 25.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,631	3,780	72,347	19.14	3
4	Licensed Practical Nurses	10,479	10,759	190,134	17.67	4
5	CNAs & Orderlies	24,357	24,494	215,323	8.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,484	1,507	15,012	9.96	9
10	Activity Assistants					10
11	Social Service Workers	1,364	1,547	18,816	12.16	11
12	Dietician	12,244	12,602	111,511	8.85	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,648	4,173	86,935	20.83	17
18	Housekeepers	4,899	4,992	43,746	8.76	18
19	Laundry	2,898	2,909	24,746	8.51	19
20	Administrator	1,544	2,087	47,964	22.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,696	4,028	54,738	13.59	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	375	375	5,668	15.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	72,382	75,339	\$ 939,767 *	\$ 12.47	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	\$ 1,728	1,3	35
36	Medical Director	Contract	12,000	9,3	36
37	Medical Records Consultant	16	1,097	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	1,522	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	27	1,763	11,3	44
45	Social Service Consultant	26	1,763	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	117	\$ 19,873		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karen Kinder	Administrator	100	\$ 47,964	Workers' Compensation Insurance	\$ 63,287	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	17,997	Advertising: Employee Recruitment	1,430	
				FICA Taxes	71,883	Health Care Worker Background Check (Indicate # of checks performed <u>23</u>)	465	
				Employee Health Insurance	33,871	Patient Background Checks		
				Employee Meals		Dues & Subscriptions	3,272	
				Illinois Municipal Retirement Fund (IMRF)*		Licenses & Fees	512	
				Employee Life Insurance	213			
				Employee Uniforms	301			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 47,964	TOTAL (agree to Schedule V, line 22, col.8)		\$ 7,669		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	66
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	1,005
C. Professional Services				TOTAL			Entertainment Expense (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount					
Oldfield Law Group	Legal Fees		\$ 2,188					
Automated Data Processing	Payroll Service		10,310					
Luallen, Cearlock, Barth, & Burnam	Accounting Fees		7,400					
C.J. Schlosser & Co., L.L.C.	Accounting Fees		8,129					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 28,027				TOTAL (agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications
 SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven# 0024984Report Period Beginning: 07/01/2013Ending: 06/30/2014**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 - \$2,353
- (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. \$ 364 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. \$ 99,682
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

Newton Rest Haven

Attachment to Schedule XIV

6/30/2014

		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				3,969	77,733		3,969	77,733
Licensed Speech Therapist	39,8				1,568	30,091		1,568	30,091
Licensed Physical Therapist	39,8				5,927	113,601	90	5,927	113,691
X-Ray	39,3					3,507		-	3,507
Laboratory	39,3					4,185		-	4,185
Specialty Mattresses/Overlays	39,3							-	-

Total to Schedule XIV, Line 12

-	-	11,464	229,117	90	11,464	229,207
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NEWTON REST HAVEN
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
6/30/2014

Miscellaneous Income	156.85
Prior Period Medicare Settlement	35,498.00
Miscellaneous Rebates & Refunds	206.20
Postage	7.36
Medical records copies reimbursement	9.49
Utilities-Cable	4,080.00
Insurance Reimbursements	3,441.27
Employee Loan Reimb.	420.00
	<hr/>
	43,819.17

Newton Rest Haven
Attachment to Sch. XVII
June 30, 2014

BOOK TO TAX NET INCOME RECONCILIATION

BOOK NET INCOME (LOSS)	\$ 45,310.00
DEPRECIATION ADJUSTMENT	(3,562.00)
CHARITABLE CONTRIBUTIONS	285.00
ROUNDING DIFFERENCE	(4.00)
TAX NET INCOME (LOSS), PER FEDERAL RETURN	<u><u>\$ 42,029.00</u></u>

NEWTON REST HAVEN
ADJUSTMENTS
ATTACHMENT TO SCHEDULE VI
6/30/2014

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
INTEREST To offset interest income against related expense	32	(9,265)
NURSING & MEDICAL RECORDS To offset adult day care revenue against related expense	10	(2,691)
HEAT & OTHER UTILITIES	5	(4,080)
NURSING & MEDICAL RECORDS	10	(10)
CLERICAL & GENERAL OFFICE EXPENSES-Postage	21	(7)
CLERICAL & GENERAL OFFICE EXPENSES-Rebates/Refunds	21	(206)
EMPLOYEE BENEFITS To offset miscellaneous income against related expenses	22	(572)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate PAC dues & lobbying dues	20	(1,771)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate donations	20	(285)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate promotional advertising	20	(7,446)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate sales tax paid	20	(1,480)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS To eliminate expense for 2 year IDPH license paid in 2014	20	(1,990)
EMPLOYEE BENEFITS & PAYROLL TAXES To eliminate non-care related expenses	22	(2,706)
TRAVEL & SEMINAR To eliminate non-allowable gas expense	24	(8,999)
RENT-FACILITY & GROUNDS To eliminate related party rent expense	34	(45,000)
DEPRECIATION EXPENSE To adjust for difference in mdcd vs book fixed assets	30	(348)
REAL ESTATE TAXES Eliminate real estate tax bill paid in error	33	(52)
		<hr style="width: 10%; margin-left: auto; margin-right: 0;"/> (86,908)

NEWTON REST HAVEN
RECLASSES
ATTACHMENT TO SCHEDULE V
6/30/2014

<u>DESCRIPTION</u>	<u>LINE #</u>	<u>INCREASE (DECREASE)</u>
LAUNDRY SUPPLIES	4	(364)
NURSING & MEDICAL RECORDS SUPPLIES	10	364

To reclass disposable diaper expense to the correct line