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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0053819

Facility Name: Newton Care Center

Address: 300 S Scott Ave B360 (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			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Daniel S. Gaafar **Telephone Number:** 317-237-5500
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 1/1/2016 to 12/31/2016 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) Mike Sorrells

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Daniel S. Gaafar, Partner

(Firm Name & Address) Bradley Associates, 201 S. Capitol Ave. Suite 700, Indianapolis, IN 46225

(Telephone) 317-237-5500 Fax # 317-237-5503

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**

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

	1 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	20,862	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	20,862	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	6,486	8,053	1,786	16,325	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,486	8,053	1,786	16,325	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.25%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 11/01/2015 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 57 and days of care provided 1,743

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	126,381	10,673	2,298	139,352		139,352		139,352			1
2	Food Purchase		101,990		101,990		101,990	(972)	101,018			2
3	Housekeeping	52,489	11,922		64,411		64,411		64,411			3
4	Laundry	26,374	10,296		36,670		36,670		36,670			4
5	Heat and Other Utilities			79,694	79,694		79,694		79,694			5
6	Maintenance	42,955	5,537	40,818	89,310		89,310	516	89,826			6
7	Other (specify):*											7
8	TOTAL General Services	248,199	140,418	122,810	511,427		511,427	(456)	510,971			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	743,860	70,684	15,734	830,278		830,278	14,597	844,875			10
10a	Therapy		201	260,015	260,216		260,216	(65,859)	194,357			10a
11	Activities	22,210	1,033	2,772	26,015		26,015		26,015			11
12	Social Services	23,471		2,780	26,251		26,251		26,251			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharm. Consultant			4,208	4,208		4,208		4,208			15
16	TOTAL Health Care and Programs	789,541	71,918	297,509	1,158,968		1,158,968	(51,262)	1,107,706			16
	C. General Administration											
17	Administrative	63,253			63,253		63,253		63,253			17
18	Directors Fees											18
19	Professional Services			108,404	108,404		108,404	(59,858)	48,546			19
20	Dues, Fees, Subscriptions & Promotions			2,164	2,164		2,164	516	2,680			20
21	Clerical & General Office Expenses	76,369	16,250	56,339	148,958		148,958	39,698	188,656			21
22	Employee Benefits & Payroll Taxes			272,384	272,384		272,384	20,470	292,854			22
23	Inservice Training & Education			4,310	4,310		4,310		4,310			23
24	Travel and Seminar			12,318	12,318		12,318	11,716	24,034			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,000	30,000		30,000	189	30,189			26
27	Other (specify):*											27
28	TOTAL General Administration	139,622	16,250	485,919	641,791		641,791	12,731	654,522			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,177,362	228,586	906,238	2,312,186		2,312,186	(38,987)	2,273,199			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
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 Care Center #0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			12,864	12,864		12,864	17,838	30,702			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							34,527	34,527			32
33	Real Estate Taxes			27,998	27,998		27,998		27,998			33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles			7,475	7,475		7,475		7,475			35
36	Other (specify):*											36
37	**TOTAL Ownership**			168,337	168,337		168,337	(67,635)	100,702			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			5,448	5,448		5,448		5,448			38
39	Ancillary Service Centers		60,184	4,290	64,474		64,474		64,474			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,000	103,000		103,000		103,000			42
43	Other (specify):* **Bad Debt**			7,496	7,496		7,496	(7,496)				43
44	**TOTAL Special Cost Centers**		60,184	120,234	180,418		180,418	(7,496)	172,922			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,177,362	288,770	1,194,809	2,660,941		2,660,941	(114,118)	2,546,823			45

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(723)	2		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	(4,662)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(249)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(673)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,496)	43		24
25	Fund Raising, Advertising and Promotional	(4,959)	21		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	(36,962)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55,724)		$	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)	(58,394)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (58,394)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (114,118)		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

Newton Care Center

ID# 0053819

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Supplies	$ (2,645)	21	1
2	Bank Charges	(757)	21	2
3	Donations	(45)	21	3
4	Finance Charge and Late Fees	(1,208)	21	4
5	Marketing Travel	(5,961)	24	5
6	Misc. Income	(7,000)	21	6
7	Marketing Wages	(19,250)	21	7
8	Gifts/Flowers	(96)	21	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**	(36,962)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newton Care Center **#** 0053819 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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	(972)	0	0	0	0	0	0	0	0	0	0	(972)	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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	516	0	0	0	0	0	0	0	0	516	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(972)	0	516	0	0	0	0	0	0	0	0	(456)	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	0	0	14,597	0	0	0	0	0	0	0	0	14,597	10
10a	Therapy	0	(65,859)	0	0	0	0	0	0	0	0	0	(65,859)	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**	0	(65,859)	14,597	0	0	0	0	0	0	0	0	(51,262)	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	(59,858)	0	0	0	0	0	0	0	0	(59,858)	19
20	Fees, Subscriptions & Promotions	0	0	516	0	0	0	0	0	0	0	0	516	20
21	Clerical & General Office Expenses	(36,633)	0	76,331	0	0	0	0	0	0	0	0	39,698	21
22	Employee Benefits & Payroll Taxes	0	0	20,470	0	0	0	0	0	0	0	0	20,470	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,961)	0	17,677	0	0	0	0	0	0	0	0	11,716	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	189	0	0	0	0	0	0	0	0	189	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(42,594)	0	55,325	0	0	0	0	0	0	0	0	12,731	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(43,566)	(65,859)	70,438	0	0	0	0	0	0	0	0	(38,987)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newton Care Center # 0053819 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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	(4,662)	21,172	1,328	0	0	0	0	0	0	0	0	17,838	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	33,011	1,516	0	0	0	0	0	0	0	0	34,527	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(120,000)	0	0	0	0	0	0	0	0	0	(120,000)	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**	(4,662)	(65,817)	2,844	0	0	0	0	0	0	0	0	(67,635)	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):*	(7,496)	0	0	0	0	0	0	0	0	0	0	(7,496)	43
44	**TOTAL Special Cost Centers**	(7,496)	0	0	0	0	0	0	0	0	0	0	(7,496)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(55,724)	(131,676)	73,282	0	0	0	0	0	0	0	0	(114,118)	45

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	10a	Physical Therapy	$ 102,009	TruRehab, LLC	100.00%	$ 75,781	$ (26,228)	1
2	V	10a	Occupational Therapy	101,410	TruRehab, LLC	100.00%	75,336	(26,074)	2
3	V	10a	Speech Therapy	28,866	TruRehab, LLC	100.00%	21,223	(7,643)	3
4	V	10a	Therapy Management Fee	23,000	TruRehab, LLC	100.00%	17,086	(5,914)	4
5	V								5
6	V	30	Depreciation		MIS Properties, LLC		21,172	21,172	6
7	V	32	Interest		MIS Properties, LLC		33,011	33,011	7
8	V	34	Rent	120,000	MIS Properties, LLC			(120,000)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 375,285			$ 243,609	$ * (131,676)	14

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	6	Maintenance	$	Ide Management Group, LLC	100.00%	$ 516	$ 516	15
16	V	10	Nursing		Ide Management Group, LLC	100.00%	14,597	14,597	16
17	V	19	Professional Fees		Ide Management Group, LLC	100.00%	5,142	5,142	17
18	V	20	Dues, Fees, Subscriptions		Ide Management Group, LLC	100.00%	516	516	18
19	V	21	Clerical and General		Ide Management Group, LLC	100.00%	76,331	76,331	19
20	V	22	Employee Benefits		Ide Management Group, LLC	100.00%	20,470	20,470	20
21	V	24	Travel and Seminar		Ide Management Group, LLC	100.00%	17,677	17,677	21
22	V	26	Insurance		Ide Management Group, LLC	100.00%	189	189	22
23	V	30	Depreciation		Ide Management Group, LLC	100.00%	1,328	1,328	23
24	V	32	Interest		Ide Management Group, LLC	100.00%	1,516	1,516	24
25	V								25
26	V	19	Management Fees	65,000	Ide Management Group, LLC	100.00%		(65,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 65,000			$ 138,282	$ * 73,282	39

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	Mark Ide	50%	Cathedral Health Care Center	Jasper, IN	Ide Mgmt. Group	Indianapolis, IN	Management	1
2	Michael Sorrells	25%	Chesterton Manor	Chesterton, IN	TruRehab, LLC	Vincennes, IN	Rehab Therapies	2
3	Ashok Mohan	25%	Cloverleaf Healthcare	Knightsville, IN	Davis-Ide HC Prop.	Indianapolis, IN	Property Mgmt.	3
4			Colonial Nursing & Rehab	Crown Point, IN				4
5			Kendallville Manor	Kendallville, IN				5
6			Madison Health Care Center	Indianapolis, IN				6
7			Oak Village	Oaktown, IN				7
8			River Terrace Retirement Community	Bluffton, IN				8
9			Silver Memories Health Care	Versailles, IN				9
10			Warsaw Meadows	Warsaw, IN				10
11			Woodland Manor	Elkhart, IN				11
12			Yorktown Manor	Yorktown, IN				12
13			Edwardsville Nursing and Rehabilitation	Edwardsville, IL				13
14			Newton Care Center	Newton, IL				14
15			North Logan Health Care Center	Danville, IL				15
16			Paris Healthcare Center	Paris, IL				16
17			University Nursing and Rehab	Edwardsville, IL				17
18			Countryside Health Care Center	Sioux City, IA				18
19			Eagle Point Health Care Center	Clinton, IA				19
20			Keosauqua Health Care Center	Keosauqua, IA				20
21			Keota Health Care Center	Keota, IA				21
22			Newton Health Care Center	Newton, IA				22
23			Sigourney Health Care	Sigourney, IA				23
24			Urbandale Health Care Center	Urbandale, IA				24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	Mark Ide	Shareholder	Administrative	0.50	See Attached	1.25	3.13	Alloc Salary	$ 10,970	21-7	1
2	Michael Sorrells	Shareholder	Administrative	0.25	See Attached	1.25	3.13	Alloc Salary	5,791	21-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,761		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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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 [X] NO [ ]

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

Name of Related Organization: Ide Management Group, LLC
Street Address: 4521 Indepence Square
City / State / Zip Code: Indianapolis, IN 46203
Phone Number: ((317) 672-3363
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	6	Maintenance	Inpatient Days	520,848	21	$ 16,474	$	16,325	$ 516	1
2	10	Nursing	Inpatient Days	520,848	21	465,727	465,727	16,325	14,597	2
3	19	Professional Fees	Inpatient Days	520,848	21	164,068		16,325	5,142	3
4	20	Dues, Fees, Subscriptions	Inpatient Days	520,848	21	16,459		16,325	516	4
5	21	Clerical and general	Inpatient Days	520,848	21	2,435,345	2,155,175	16,325	76,331	5
6	22	Employee Benefits	Inpatient Days	520,848	21	653,083		16,325	20,470	6
7	24	Travel and Seminar	Inpatient Days	520,848	21	563,986		16,325	17,677	7
8	26	Insurance	Inpatient Days	520,848	21	6,020		16,325	189	8
9	30	Deprecation	Inpatient Days	520,848	21	42,379		16,325	1,328	9
10	32	Interest	Inpatient Days	520,848	21	48,362		16,325	1,516	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					$ 4,411,903	$ 2,620,902		$ 138,282	25

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	The Commerce Bank		X		$5,318.36	10/29/15	$ 680,000	$ 631,237	11/05/20	0.0475	$ 34,527	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$5,318.36		$ 680,000	$ 631,237			$ 34,527	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 680,000	$ 631,237			$ 34,527	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)**

**** 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 Care Center **#** 0053819 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	27,395	2
3. Under or (over) accrual (line 2 minus line 1).	$	27,395	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	603	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.	$	27,998	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2011		8
2012		9
2013		10
2014		11
2015	27,395	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Newton Care Center COUNTY Jasper

FACILITY IDPH LICENSE NUMBER 0053819

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	90-13-06-106-008	Nursing Facility	$ 27,031.50	$ 27,031.50
2.	90-13-06-300-036	Nursing Facility	$ 44.02	$ 44.02
3.	90-13-06-106-006	Nursing Facility	$ 319.24	$ 319.24
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,394.76	$ 27,394.76

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2015	$ 150,000	1
2					2
3	TOTALS			$ 150,000	3

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	57		2015	1969	$ 640,000	$ 16,410	39	$ 16,410	$	$ 19,145	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Outdoor Signage			12/14/2015	3,995	200	20	200		217	9
10											10
11	Outdoor Signs			1/6/2016	385	19	20	19		19	11
12	Quick Lock Vinyl Strip Flooring			5/26/2016	3,170	92	20	92		92	12
13	Dining Room Renovation			5/26/2016	11,600	338	20	338		338	13
14	Flooring			7/13/2016	1,097	27	20	27		27	14
15	Quick Lock Vinyl Strip Flooring			8/9/2016	878	18	20	18		18	15
16	Vinyl Plank Flooring			9/2/2016	549	9	20	9		9	16
17	Flooring			10/4/2016	2,194	27	20	27		27	17
18	Roof			11/30/2016	90,404	377	20	377		377	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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)		$ 754,272	$ 17,517		$ 17,517	$	$ 20,269	70

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 27,442	$ 4,917	$ 4,917	$	5	$ 5,737	71
72	Current Year Purchases	42,883	3,333	3,333		7	3,332	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 70,325	$ 8,250	$ 8,250	$		$ 9,069	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	Patient transportation	2008 Starcraft E350	2016	$ 32,900	$ 4,935	$ 4,935	$	5	$ 4,935	76
77										77
78										78
79										79
80	TOTALS			$ 32,900	$ 4,935	$ 4,935	$		$ 4,935	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)	$ 1,007,497	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,702	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,702	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)	$ 34,273	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 7,475 Description:
(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.

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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.

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	1,780	$ 101,410	$	1,780	$ 101,410	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		401	28,866		401	28,866	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,995	102,009		1,995	102,009	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				60,184		60,184	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-3					3,116		3,116	12
13	Other (specify): X-Ray	39-3					1,174		1,174	13
14	TOTAL			$	4,176	$ 232,285	$ 64,474	4,176	$ 296,759	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.

Facility Name & ID Number Newton Care Center **#** 0053819 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 9,690	$ 11,188	1
2	Cash-Patient Deposits	20,526	20,526	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	447,294	447,294	3
4	Supply Inventory (priced at)	3,763	3,763	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,618	17,618	6
7	Other Prepaid Expenses	(8,300)	(8,300)	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Party	22,958	102,458	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 513,549	$ 594,547	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost	114,271	754,271	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	93,224	103,224	16
17	Accumulated Depreciation (book methods)	(13,462)	(34,274)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		50,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,889)	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)**	$ 194,033	$ 1,019,332	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 707,582	$ 1,613,879	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 563,901	$ 563,901	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	300	228,215	29
30	Accrued Salaries Payable	(862)	(862)	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,800	7,800	31
32	Accrued Real Estate Taxes(Sch.IX-B)	966	966	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Prior Owner	18,342	18,342	36
37	Resident Trust Fund	20,526	20,526	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 610,973	$ 838,888	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		631,237	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)**	$	$ 631,237	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 610,973	$ 1,470,125	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 96,609	$ 143,754	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 707,582	$ 1,613,879	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,611	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,611	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	85,998	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)**	$ 85,998	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)**	$ 96,609	24 *

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

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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	$ 2,244,219	1
2	Discounts and Allowances for all Levels	(17,869)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,226,350	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	459,770	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 459,770	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	723	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	43,361	17
18	Sale of Supplies to Non-Patients	7,865	18
19	Laboratory	1,025	19
20	Radiology and X-Ray	845	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 53,819	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Misc. Income	7,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,746,939	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	511,427	31
32	Health Care	1,158,968	32
33	General Administration	641,791	33
	B. Capital Expense		
34	Ownership	168,337	34
	C. Ancillary Expense		
35	Special Cost Centers	77,418	35
36	Provider Participation Fee	103,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,660,941	40
41	**Income before Income Taxes (line 30 minus line 40)****	85,998	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 85,998	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 720,580	44
45	Private Pay - Net Inpatient Revenue	1,101,527	45
46	Medicare - Net Inpatient Revenue	423,048	46
47	Other-(specify) Managed Care - Net Inpatient Revenue	(18,805)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,226,350	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.**

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

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

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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	727	794	$ 52,250	$ 65.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,597	13,914	308,798	22.19	3
4	Licensed Practical Nurses	2,707	2,707	52,060	19.23	4
5	CNAs & Orderlies	30,021	30,601	327,995	10.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,163	2,226	22,210	9.98	9
10	Activity Assistants					10
11	Social Service Workers	2,071	2,152	23,471	10.91	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,987	12,380	126,381	10.21	15
16	Dishwashers					16
17	Maintenance Workers	2,020	2,181	42,955	19.70	17
18	Housekeepers	5,709	5,882	52,489	8.92	18
19	Laundry	2,921	3,019	26,374	8.74	19
20	Administrator	1,356	1,468	63,253	43.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,926	5,192	76,369	14.71	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	290	290	2,757	9.51	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	80,495	82,806	$ 1,177,362 *	$ 14.22	34

* 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	99	$ 1,791	1-3	35
36	Medical Director	240	12,000	9-3	36
37	Medical Records Consultant	45	2,256	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	70	4,208	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	59	1,831	11-3	44
45	Social Service Consultant	51	1,583	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	564	$ 23,669		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paula Schoonover	Administrator		$ 63,253
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,253

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
Parrish Consulting Services, Inc.	Technology	$ 11,244
Integrated Resources Mgmt.	Payroll	32,160
Ide Management Group	Professional/Mgmt.	65,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 108,404

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,346
Unemployment Compensation Insurance	23,775
FICA Taxes	87,275
Employee Health Insurance	107,876
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	385
Employee Physicals	717
Human Resources	6,010
Ide Management Group	20,470
TOTAL (agree to Schedule V, line 22, col.8)	$ 292,854

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Jasper County Chamber of Commerce	270
Illinois Department of Public Health	1,849
Sam's Club	45
Ide Management Group	515
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,679

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	3,598
Parking	242
Seminar Expense	
Education	454
Hotel	2,063
Ide Management Group	17,677
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,034

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(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? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,791** 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. $ **103,000**
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? **0%**
d. Have vehicle usage logs been maintained? **Yes**
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