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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053819

Facility Name: Newton Care Center

Address: 300 S Scott Avenue (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: Paul Traczek **Telephone Number:** 715-858-6619
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 1/1/2017 to 12/31/2017 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) Paul Traczek, Partner
(Firm Name & Address) Wipfli LLP, 3703 Oakwood Hills Parkway, Eau Claire, WI 54702
(Telephone) 715-858-6619 Fax # 715-832-2345

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: 1/1/2017 Ending: 12/31/2017

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,282	7,229	2,760	17,271	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,282	7,229	2,760	17,271	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.01%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 8/1/1969

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 2,719

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	114,161	8,929	4,039	127,129		127,129		127,129			1
2	Food Purchase		106,236		106,236		106,236	(8,935)	97,301			2
3	Housekeeping	52,796	16,899	435	70,130		70,130		70,130			3
4	Laundry	26,993	5,536	2,349	34,878		34,878		34,878			4
5	Heat and Other Utilities			87,428	87,428		87,428		87,428			5
6	Maintenance	51,315	1,429	30,086	82,830		82,830	1,521	84,351			6
7	Other (specify):*											7
8	TOTAL General Services	245,265	139,029	124,337	508,631		508,631	(7,414)	501,217			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	895,127	53,827	19,404	968,358		968,358	16,488	984,846			10
10a	Therapy		1,154	318,337	319,491		319,491	(135,818)	183,673			10a
11	Activities	27,438	944	3,740	32,122		32,122		32,122			11
12	Social Services	28,712		1,593	30,305		30,305		30,305			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	951,277	55,925	355,074	1,362,276		1,362,276	(119,330)	1,242,946			16
	C. General Administration											
17	Administrative	65,529			65,529		65,529		65,529			17
18	Directors Fees											18
19	Professional Services			112,182	112,182		112,182	3,178	115,360			19
20	Dues, Fees, Subscriptions & Promotions			12,862	12,862		12,862		12,862			20
21	Clerical & General Office Expenses	75,215	7,723	44,829	127,767		127,767	2,997	130,764			21
22	Employee Benefits & Payroll Taxes			271,853	271,853		271,853	18,876	290,729			22
23	Inservice Training & Education			1,665	1,665		1,665		1,665			23
24	Travel and Seminar			13,663	13,663		13,663	9,965	23,628			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			27,500	27,500		27,500	(339)	27,161			26
27	Other (specify):* Bad Debt			4,290	4,290		4,290	(4,290)				27
28	TOTAL General Administration	140,744	7,723	488,844	637,311		637,311	30,387	667,698			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,337,286	202,677	968,255	2,508,218		2,508,218	(96,357)	2,411,861			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: 1/1/2017 Ending: 12/31/2017

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			24,096	24,096		24,096	6,797	30,893			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,938	20,938		20,938	36,587	57,525			32
33	Real Estate Taxes			25,664	25,664		25,664		25,664			33
34	Rent-Facility & Grounds			120,000	120,000		120,000	(120,000)				34
35	Rent-Equipment & Vehicles			10,244	10,244		10,244		10,244			35
36	Other (specify):*											36
37	**TOTAL Ownership**			200,942	200,942		200,942	(76,616)	124,326			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,336	5,538	61,874		61,874		61,874			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			120,484	120,484		120,484		120,484			42
43	Other (specify):* **Residential**		206	3,290	3,496		3,496		3,496			43
44	**TOTAL Special Cost Centers**		56,542	129,312	185,854		185,854		185,854			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,337,286	259,219	1,298,509	2,895,014		2,895,014	(172,973)	2,722,041			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: 1/1/2017 Ending: 12/31/2017

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	(95)	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	(12,375)	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	(8,840)	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		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	(4,290)	27		24
25	Fund Raising, Advertising and Promotional	(5,345)	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	(15,679)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (46,624)		$	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)	(126,349)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (126,349)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (172,973)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Newton Care Center

ID# 0053819

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Supplies	$ (3,433)	21	1
2	Bank Charges	(1,191)	21	2
3	Donations	(100)	21	3
4	Finance Charge and Late Fees	(378)	21	4
5	Marketing Travel	(566)	24	5
6	Misc. Income	(3,419)	21	6
7	Marketing Wages	(5,798)	21	7
8	Gifts/Flowers	(794)	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**	(15,679)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newton Care Center **#** 0053819 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	(8,935)	0	0	0	0	0	0	0	0	0	0	(8,935)	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	1,521	0	0	0	0	0	0	0	0	1,521	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,935)	0	1,521	0	0	0	0	0	0	0	0	(7,414)	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	16,488	0	0	0	0	0	0	0	0	16,488	10
10a	Therapy	0	(135,818)	0	0	0	0	0	0	0	0	0	(135,818)	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	(135,818)	16,488	0	0	0	0	0	0	0	0	(119,330)	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	3,178	0	0	0	0	0	0	0	0	3,178	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(20,458)	0	23,455	0	0	0	0	0	0	0	0	2,997	21
22	Employee Benefits & Payroll Taxes	0	0	18,876	0	0	0	0	0	0	0	0	18,876	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(566)	0	10,531	0	0	0	0	0	0	0	0	9,965	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	(339)	0	0	0	0	0	0	0	0	(339)	26
27	Other (specify):*	(4,290)	0	0	0	0	0	0	0	0	0	0	(4,290)	27
28	**TOTAL General Administration**	(25,314)	0	55,701	0	0	0	0	0	0	0	0	30,387	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,249)	(135,818)	73,710	0	0	0	0	0	0	0	0	(96,357)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newton Care Center # 0053819 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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	(12,375)	17,844	1,328	0	0	0	0	0	0	0	0	6,797	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	33,291	3,296	0	0	0	0	0	0	0	0	36,587	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**	(12,375)	(68,865)	4,624	0	0	0	0	0	0	0	0	(76,616)	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)**	(46,624)	(204,683)	78,334	0	0	0	0	0	0	0	0	(172,973)	45

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. ☐ 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	$ 115,774	TruRehab, LLC	100.00%	$ 85,997	$ (29,777)	1
2	V	10a	Occupational Therapy	377,077	TruRehab, LLC	100.00%	280,093	(96,984)	2
3	V	10a	Speech Therapy	10,212	TruRehab, LLC	100.00%	7,585	(2,627)	3
4	V	10a	Therapy Management	25,000	TruRehab, LLC	100.00%	18,570	(6,430)	4
5	V								5
6	V	30	Depreciation		MIS Properties, LLC		17,844	17,844	6
7	V	32	Interest		MIS Properties, LLC		33,291	33,291	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			$ 648,063			$ 443,380	$ * (204,683)	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: 1/1/2017 Ending: 12/31/2017

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%	$ 1,521	$ 1,521	15
16	V	10	Nursing		Ide Management Group LLC	100.00%	16,488	16,488	16
17	V	19	Professional Fees		Ide Management Group LLC	100.00%	3,178	3,178	17
18	V	20	Dues, Fees, Subscriptions		Ide Management Group LLC	100.00%			18
19	V	21	Clerical and General		Ide Management Group LLC	100.00%	83,455	83,455	19
20	V	22	Employee Benefits		Ide Management Group LLC	100.00%	18,876	18,876	20
21	V	24	Travel and Seminar		Ide Management Group LLC	100.00%	10,531	10,531	21
22	V	26	Insurance		Ide Management Group LLC	100.00%	(339)	(339)	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%	3,296	3,296	24
25	V								25
26	V	21	Management Fees	60,000	Ide Management Group LLC	100.00%		(60,000)	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			$ 60,000			$ 138,334	$ * 78,334	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: 1/1/2017 Ending: 12/31/2017

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 Moran	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	Oakton 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			Yorkton 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: 1/1/2017 Ending: 12/31/2017

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	100.00	See Attached	1.25	3.12	Alloc Salary	$ 10,927	21-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,927		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: 1/1/2017 Ending: 2/31/2017

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 Independence Square
City / State / Zip Code: Indianapolis, IN 46203
Phone Number: (317-744-9148
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	553,224	22	$ 48,729	$	17,271	$ 1,521	1
2	10	Nursing	Inpatient Days	553,224	22	528,158	528,158	17,271	16,488	2
3	19	Professional Fees	Inpatient Days	553,224	22	101,802		17,271	3,178	3
4	20	Dues, Fees, Subscriptions	Inpatient Days	553,224	22	0		17,271	0	4
5	21	Clerical and General	Inpatient Days	553,224	22	2,673,220	2,656,119	17,271	83,455	5
6	22	Employee Benefits	Inpatient Days	553,224	22	604,640		17,271	18,876	6
7	24	Travel and Seminar	Inpatient Days	553,224	22	337,331		17,271	10,531	7
8	26	Insurance	Inpatient Days	553,224	22	(10,862)		17,271	(339)	8
9	30	Depreciation	Inpatient Days	553,224	22	42,543		17,271	1,328	9
10	32	Interest	Inpatient Days	553,224	22	105,593		17,271	3,296	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					$ 4,431,154	$ 3,184,277		$ 138,334	25

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 500,000	11/05/20	0.0475	$ 20,938	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	$ 500,000			$ 20,938	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	$ 500,000			$ 20,938	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:** 1/1/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	603	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.)	$	27,182	2
3. Under or (over) accrual (line 2 minus line 1).	$	26,579	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	(915)	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.	$	25,664	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013		9
2014		10
2015	27,395	11
2016	27,182	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	$	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.**

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Newton Care Center COUNTY Jasper

FACILITY IDPH LICENSE NUMBER 0053819

CONTACT PERSON REGARDING THIS REPORT Paul Traczek

TELEPHONE 715-858-6619 FAX #: 715-832-2345

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	90-13-06-106-008	Nursing Facility	$ 27,135.06	$ 27,135.06
2.	90-13-06-300-036	Nursing Facility	$ 46.60	$ 46.60
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,181.66	$ 27,181.66

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

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	$	$ 35,555	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Outdoor Signage			2015	3,995	200	20	200		417	9
10											10
11	Outdoor Signs			2016	385	19	20	19		38	11
12	Quick Lock Vinyl Strip Flooring			2016	3,170	159	20	159		251	12
13	Dining Room Renovation			2016	11,600	580	20	580		918	13
14	Flooring			2016	1,097	55	20	55		82	14
15	Quick Lock Vinyl Strip Flooring			2016	878	44	20	44		62	15
16	Vinyl Plank Flooring			2016	549	27	20	27		36	16
17	Flooring			2016	2,194	110	20	110		137	17
18	Rood			2016	90,404	4,520	20	4,520		4,897	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: 1/1/2017 Ending: 12/31/2017

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	$ 22,124		$ 22,124	$	$ 42,393	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: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 60,325	$ 9,615	$	$ (9,615)	5-7	$ 17,015	71
72	Current Year Purchases	24,533	2,189	2,189		7	2,189	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 84,858	$ 11,804	$ 2,189	$ (9,615)		$ 19,204	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	$ 6,580	$ 6,580	$	5	$ 11,515	76
77										77
78										78
79										79
80	TOTALS			$ 32,900	$ 6,580	$ 6,580	$		$ 11,515	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)	$ 1,022,030	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,508	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,893	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,615)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 73,112	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: 1/1/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 10,244 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: 1/1/2017 Ending: 12/31/2017

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.

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	$	2,283	$ 130,077	$	2,283	$ 130,077	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		477	34,365		477	34,365	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,519	128,818		2,519	128,818	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				56,336		56,336	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-3					2,898		2,898	12
13	Other (specify): X-Ray	39-3					2,640		2,640	13
14	TOTAL			$	5,280	$ 293,260	$ 61,874	5,280	$ 355,134	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: 1/1/2017 Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 19,526	$	1
2	Cash-Patient Deposits	20,526		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	452,944		3
4	Supply Inventory (priced at)	3,872		4
5	Short-Term Investments			5
6	Prepaid Insurance	10,467		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Party			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 507,335	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	385		13
14	Buildings, at Historical Cost	115,027		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	116,617		16
17	Accumulated Depreciation (book methods)	(37,558)		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)**	$ 194,471	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 701,806	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 217,069	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	(497,633)		29
30	Accrued Salaries Payable	83,442		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,800		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,665		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	25,278		36
37	Resident Trust Fund	20,526		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (117,853)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	500,000		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)**	$ 500,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 382,147	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 319,659	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 701,806	$	48

***(See instructions.)**

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 96,609	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(107,899)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (11,290)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	330,949	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)**	$ 330,949	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)**	$ 319,659	24 *

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 2,578,757	1
2	Discounts and Allowances for all Levels	13,574	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,592,331	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	561,251	6
7	Oxygen	1,804	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 563,055	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	95	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,673	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,299	19
20	Radiology and X-Ray	715	20
21	Other Medical Services	2,758	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 64,540	23
	D. Non-Operating Revenue		
24	Contributions	(100)	24
25	Interest and Other Investment Income***	2,718	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,618	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	3,419	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,419	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,225,963	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	508,631	31
32	Health Care	1,362,276	32
33	General Administration	637,311	33
	B. Capital Expense		
34	Ownership	200,942	34
	C. Ancillary Expense		
35	Special Cost Centers	65,370	35
36	Provider Participation Fee	120,484	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,895,014	40
41	**Income before Income Taxes (line 30 minus line 40)****	330,949	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 330,949	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 745,623	44
45	Private Pay - Net Inpatient Revenue	1,142,271	45
46	Medicare - Net Inpatient Revenue	606,652	46
47	Other-(specify) Managed Care - Net Inpatient Revenue	97,785	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,592,331	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.**

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	916	1,000	$ 66,250	$ 66.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,273	12,984	304,089	23.42	3
4	Licensed Practical Nurses	3,505	3,561	67,619	18.99	4
5	CNAs & Orderlies	35,465	36,691	475,134	12.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,377	2,432	24,171	9.94	9
10	Activity Assistants					10
11	Social Service Workers	1,966	2,086	27,314	13.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,846	11,248	107,586	9.56	15
16	Dishwashers					16
17	Maintenance Workers	2,217	2,453	46,388	18.91	17
18	Housekeepers	5,528	5,862	51,099	8.72	18
19	Laundry	2,801	2,961	25,799	8.71	19
20	Administrator	1,300	1,300	65,529	50.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,291	4,667	74,227	15.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	219	219	2,081	9.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	83,704	87,464	$ 1,337,286 *	$ 15.29	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	138	$ 2,483	1-3	35
36	Medical Director	240	12,000	9-3	36
37	Medical Records Consultant	34	1,691		37
38	Nurse Consultant				38
39	Pharmacist Consultant	85	5,081	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	51	1,593	11-3	44
45	Social Service Consultant	51	1,593	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	599	$ 24,441		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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Schoonover	Administrator		$ 65,529
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,529

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.	IT	$ 6,060
Integrated Resources Mgmt.	Payroll	40,467
BKD	Accounting	7,823
Lucas Accounting Solutions, LLC	Accounting	1,000
Legal	Legal	10
Ide Management Group	Professional/Mgmt	60,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 115,360

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,849
Unemployment Compensation Insurance	23,343
FICA Taxes	99,396
Employee Health Insurance	93,415
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	5,405
Human Resources	1,445
Ide Management Group	18,876
TOTAL (agree to Schedule V, line 22, col.8)	$ 290,729

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,579
Health Care Worker Background Check	
(Indicate # of checks performed)	
Resident Background Check	600
Dues & Subscriptions	1,148
Advertising Expense	5,345
Licenses & Permits	2,190
Ide Management Group	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,862

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	9,887
Seminar Expense	
Education	477
Hotel	2,733
Ide Management Group	10,531
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,628

**See instructions.

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. $ **16,588** 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. $ **120,484**
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? **100%**
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?
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