FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

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: 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 1/1/2018 to 12/31/2018 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) Debbie Baynes
(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: 1/1/2018 Ending: 12/31/2018

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	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,805	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,382	8,007	2,351	16,740	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,382	8,007	2,351	16,740	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.46%

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 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 2,160

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	110,599	9,977	2,436	123,012		123,012		123,012			1
2	Food Purchase		105,331		105,331		105,331	(339)	104,992			2
3	Housekeeping	46,331	13,533		59,864		59,864		59,864			3
4	Laundry	29,725	12,497		42,222		42,222		42,222			4
5	Heat and Other Utilities			78,052	78,052		78,052	1,496	79,548			5
6	Maintenance	46,762	3,208	30,469	80,439		80,439	331	80,770			6
7	Other (specify):*											7
8	TOTAL General Services	233,417	144,546	110,957	488,920		488,920	1,488	490,408			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	825,204	47,792	13,070	886,066		886,066	11,435	897,501			10
10a	Therapy		536	361,982	362,518		362,518	2,067	364,585			10a
11	Activities	16,117	1,005	3,536	20,658		20,658		20,658			11
12	Social Services	27,650		2,860	30,510		30,510		30,510			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharm. Consultant			4,050	4,050		4,050		4,050			15
16	TOTAL Health Care and Programs	868,971	49,333	396,498	1,314,802		1,314,802	13,502	1,328,304			16
	C. General Administration											
17	Administrative	73,241			73,241		73,241		73,241			17
18	Directors Fees											18
19	Professional Services			107,570	107,570		107,570	(55,282)	52,288			19
20	Dues, Fees, Subscriptions & Promotions			4,410	4,410		4,410	233	4,643			20
21	Clerical & General Office Expenses	70,310	9,177	53,988	133,475		133,475	61,693	195,168			21
22	Employee Benefits & Payroll Taxes			257,450	257,450		257,450	19,354	276,804			22
23	Inservice Training & Education			543	543		543		543			23
24	Travel and Seminar			3,834	3,834		3,834	8,419	12,253			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,746	37,746		37,746	1,978	39,724			26
27	Other (specify):*											27
28	TOTAL General Administration	143,551	9,177	465,541	618,269		618,269	36,395	654,664			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,245,939	203,056	972,996	2,421,991		2,421,991	51,385	2,473,376			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: 1/1/2018 Ending: 12/31/2018

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			29,955	29,955		29,955	19,830	49,785			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,486	28,486		28,486	44,344	72,830			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			7,305	7,305		7,305		7,305			35
36	Other (specify):*											36
37	**TOTAL Ownership**			213,744	213,744		213,744	(55,826)	157,918			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			124	124		124		124			38
39	Ancillary Service Centers		59,238	5,621	64,859		64,859		64,859			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			140,071	140,071		140,071		140,071			42
43	Other (specify):* **Bad Debt**			10,888	10,888		10,888	(10,888)				43
44	**TOTAL Special Cost Centers**		59,238	156,704	215,942		215,942	(10,888)	205,054			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,245,939	262,294	1,343,444	2,851,677		2,851,677	(15,329)	2,836,348			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: 1/1/2018 Ending: 12/31/2018

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	(90)	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				9
10	Interest and Other Investment Income	(791)	32		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	(1,278)	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	(10,888)	43		24
25	Fund Raising, Advertising and Promotional	(7,039)	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	(9,871)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,206)		$	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)	14,877	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 14,877		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (15,329)		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: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jasper County Chamber of Commerce Dues	$ (270)	20	1
2	Marketing Supplies	(2,349)	21	2
3	Bank Charges	(500)	21	3
4	Donations	(545)	21	4
5	Finance Charge and Late Fees	(300)	21	5
6	Gifts/Flowers	(1,332)	21	6
7	Marketing Wages	(4,261)	21	7
8	Misc. Income	(289)	21	8
9	Bank Charges (Related Party)	(25)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,871)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(339)	0	0	0	0	0	0	0	0	0	0	(339)	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	1,496	0	0	0	0	0	0	0	0	1,496	5
6	Maintenance	0	0	331	0	0	0	0	0	0	0	0	331	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(339)	0	1,827	0	0	0	0	0	0	0	0	1,488	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	11,435	0	0	0	0	0	0	0	0	11,435	10
10a	Therapy	0	2,067	0	0	0	0	0	0	0	0	0	2,067	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	2,067	11,435	0	0	0	0	0	0	0	0	13,502	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	(55,282)	0	0	0	0	0	0	0	0	(55,282)	19
20	Fees, Subscriptions & Promotions	(270)	0	503	0	0	0	0	0	0	0	0	233	20
21	Clerical & General Office Expenses	(17,918)	25	79,586	0	0	0	0	0	0	0	0	61,693	21
22	Employee Benefits & Payroll Taxes	0	0	19,354	0	0	0	0	0	0	0	0	19,354	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,419	0	0	0	0	0	0	0	0	8,419	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	1,978	0	0	0	0	0	0	0	0	1,978	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(18,188)	25	54,558	0	0	0	0	0	0	0	0	36,395	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,527)	2,092	67,820	0	0	0	0	0	0	0	0	51,385	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newton Care Center # 0053819 **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	17,844	1,986	0	0	0	0	0	0	0	0	19,830	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(791)	34,068	11,067	0	0	0	0	0	0	0	0	44,344	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**	(791)	(68,088)	13,053	0	0	0	0	0	0	0	0	(55,826)	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):*	(10,888)	0	0	0	0	0	0	0	0	0	0	(10,888)	43
44	**TOTAL Special Cost Centers**	(10,888)	0	0	0	0	0	0	0	0	0	0	(10,888)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,206)	(65,996)	80,873	0	0	0	0	0	0	0	0	(15,329)	45

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Therapy	$ 357,641	TruRehab, LLC		$ 359,708	$ 2,067	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V	21	Clerical and General		MIS Properties, LLC		25	25	6
7	V	30	Depreciation		MIS Properties, LLC		17,844	17,844	7
8	V	32	Interest		MIS Properties, LLC		34,068	34,068	8
9	V	34	Rent	120,000	MIS Properties, LLC			(120,000)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 477,641			$ 411,645	$ * (65,996)	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: 1/1/2018 Ending: 12/31/2018

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	5	Utilities	$	Ide Management Group, LLC		$ 1,496	$ 1,496	15
16	V	6	Maintenance		Ide Management Group, LLC		331	331	16
17	V	10	Nursing		Ide Management Group, LLC		11,435	11,435	17
18	V	19	Professional Services		Ide Management Group, LLC		4,718	4,718	18
19	V	20	Dues and Subscriptions		Ide Management Group, LLC		503	503	19
20	V	21	Clerical & General		Ide Management Group, LLC		79,586	79,586	20
21	V	22	Employee Benefits		Ide Management Group, LLC		19,354	19,354	21
22	V	24	Travel and Seminar		Ide Management Group, LLC		8,419	8,419	22
23	V	26	Insurance		Ide Management Group, LLC		1,978	1,978	23
24	V	30	Depreciation		Ide Management Group, LLC		1,986	1,986	24
25	V	32	Interest		Ide Management Group, LLC		11,067	11,067	25
26	V								26
27	V	19	Management Fees	60,000	Ide Management Group, LLC			(60,000)	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			$ 140,873	$ * 80,873	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: 1/1/2018 Ending: 12/31/2018

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	75%	Cathedral Health Care Center	Jasper, IN	Ide Mgmt. Group	Indianapolis, IN	Management	1
2	Ashok Mohan	25%	Chesterton Manor	Chesterton, IN	TruRehab, LLC	Vincennes, IN	Rehab Therapies	2
3			Cloverleaf Healthcare	Knightsville, IN	MIS Properties, LLC	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			Newton Care Center	Newton, IL				13
14			North Logan Health Care Center	Danville, IL				14
15			Paris Healthcare Center	Paris, IL				15
16			Countryside Health Care Center	Sioux City, IA				16
17			Eagle Point Health Care Center	Clinton, IA				17
18			Keosauqua Health Care Center	Keosauqua, IA				18
19			Keota Health Care Center	Keota, IA				19
20			Newton Health Care Center	Newton, IA				20
21			Sigourney Health Care	Sigourney, IA				21
22			Urbandale Health Care Center	Urbandale, IA				22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	75.00	See Attached	1.38	3.46	Alloc Salary	$ 12,113	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	$ 12,113		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: 1/1/2018 Ending: 2/31/2018

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) 744-9184
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	5	Utilities	Inpatient Days	483,703	24	$ 43,224	$	16,740	$ 1,496	1
2	6	Maintenance	Inpatient Days	483,703	24	9,566		16,740	331	2
3	10	Nursing	Inpatient Days	483,703	24	330,413	330,413	16,740	11,435	3
4	19	Professional Services	Inpatient Days	483,703	24	136,325		16,740	4,718	4
5	20	Dues and Subscriptions	Inpatient Days	483,703	24	14,545		16,740	503	5
6	21	Clerical & General	Inpatient Days	483,703	24	2,299,646	1,819,582	16,740	79,586	6
7	22	Employee Benefits	Inpatient Days	483,703	24	559,236		16,740	19,354	7
8	24	Travel and Seminar	Inpatient Days	483,703	24	243,272		16,740	8,419	8
9	26	Insurance	Inpatient Days	483,703	24	57,161		16,740	1,978	9
10	30	Depreciation	Inpatient Days	483,703	24	57,393		16,740	1,986	10
11	32	Interest	Inpatient Days	483,703	24	319,783		16,740	11,067	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					$ 4,070,564	$ 2,149,995		$ 140,873	25

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Mortgage	$5,318.36	10/29/15	$ 680,000	$ 577,742	11/05/20	0.0475	$ 34,068	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Banterra Bank		X	Line of Credit		08/19/15	500,000	499,284	02/16/2019	0.0525	28,486	6
7												7
8												8
9	TOTAL Facility Related				$5,318.36		$ 1,180,000	$ 1,077,026			$ 62,554	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,180,000	$ 1,077,026			$ 62,554	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: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ (915)	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.)		$ 28,927	2
3. Under or (over) accrual (line 2 minus line 1).		$ 29,842	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (1,844)	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:		
2013		8
2014		9
2015	27,395	10
2016	27,182	11
2017	28,927	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	90-13-06-106-008	Nursing Facility	$ 28,877.18	$ 28,877.18
2.	90-13-06-300-036	Nursing Facility	$ 49.56	$ 49.56
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 28,926.74	$ 28,926.74

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: 12/31/2018

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	$	$ 51,965	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Outdoor Signage			2015	3,995	200	20	200		617	9
10											10
11	Outdoor Signs			2016	385	19	20	19		57	11
12	Quick Lock Vinyl Strip Flooring for Resident Rooms 45, 47, 49 & 51			2016	3,170	159	20	159		410	12
13	Dining Room Renovation: Remove wall tiles; prepare walls for painting:			2016	11,600	580	20	580		1,498	13
14	paint all walls, two coats and ceiling; installation of 10 new cloud lights										14
15	(ceiling patched prior to painting, rewiring performed as needed)										15
16	Flooring for Administrator Office			2016	1,097	55	20	55		137	16
17	Quick Lock Vinyl Strip Flooring for Receptionist Office and Front Office			2016	878	44	20	44		106	17
18	Bathroom										18
19	Vinyl Plank Flooring for Lobby			2016	549	27	20	27		63	19
20	Flooring for Lobby			2016	2,194	110	20	110		247	20
21	Roof (labor and materials to remove and replace old roof)			2016	90,404	4,520	20	4,520		9,417	21
22											22
23	Water Softener 2900 Duplex NXT			2018	7,861	66	20	66		66	23
24	11-13 Comdial System with NEC Hardware			2018	4,944	21	20	21		21	24
25	299000 BTU 95% Boiler			2018	14,000		20				25
26	Flooring Material for Private Rooms 1, 5, 7, 11, 17, 19, 21, 23, 25, South ha			2018	4,508	150	20	150		150	26
27	Rooms 33, 37, 39						20				27
28	Flooring Installation			2018	11,286	282	20	282		282	28
29	Pipe Water Softener to Meter			2018	2,350	10	20	10		10	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: 1/1/2018 Ending: 12/31/2018

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)		$ 799,221	$ 22,653		$ 22,653	$	$ 65,046	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: 1/1/2018 Ending: 12/31/2018

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	$ 94,858	$ 16,537	$ 16,537	$	5 - 7	$ 36,419	71
72	Current Year Purchases	56,669	3,888	3,888		7	3,888	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 151,527	$ 20,425	$ 20,425	$		$ 40,307	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	$ 18,095	76
77	Patient transportation	AC Compressor - Van	2018	1,898	127	127		5	127	77
78										78
79										79
80	TOTALS			$ 34,798	$ 6,707	$ 6,707	$		$ 18,222	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)	$ 1,135,546	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 49,785	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 49,785	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)	$ 123,575	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: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ ____ 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: 1/1/2018 Ending: 12/31/2018

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	$	2,191	$ 91,050	$	2,191	$ 91,050	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		836	6,696		836	6,696	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,697	118,832		2,697	118,832	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				59,238		59,238	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Lab	39-3					3,186		3,186	12
13	Other (specify): X-Ray & Phys. Fees	39-3					2,435		2,435	13
14	TOTAL			$	5,724	$ 216,578	$ 64,859	5,724	$ 281,437	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: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ 114,140	$ 115,587	1
2	Cash-Patient Deposits	20,526	20,526	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	340,785	340,785	3
4	Supply Inventory (priced at)	3,873	3,873	4
5	Short-Term Investments			5
6	Prepaid Insurance	3,103	3,103	6
7	Other Prepaid Expenses	3,050	3,050	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Party	698,416	635,414	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,183,893	$ 1,122,338	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	159,220	799,220	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	176,325	186,325	16
17	Accumulated Depreciation (book methods)	(67,514)	(123,170)	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): Intangibles		10,553	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 268,031	$ 1,022,928	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,451,924	$ 2,145,266	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 166,807	$ 166,807	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	499,284	561,448	29
30	Accrued Salaries Payable	89,326	89,326	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,492	37,492	31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,736	24,736	32
33	Accrued Interest Payable		1,982	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Prior Owner	25,278	25,278	36
37	Resident Trust Fund	20,526	20,526	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 863,449	$ 927,595	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		577,742	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)**	$	$ 577,742	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 863,449	$ 1,505,337	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 588,475	$ 639,929	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,451,924	$ 2,145,266	48

***(See instructions.)**

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 319,659	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 319,659	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	348,736	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	(79,920)	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)**	$ 268,816	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)**	$ 588,475	24 *

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

Facility Name & ID Number Newton Care Center # 0053819 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 2,467,550	1
2	Discounts and Allowances for all Levels	46,773	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,514,323	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	611,407	6
7	Oxygen	3,242	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 614,649	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	90	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	67,607	17
18	Sale of Supplies to Non-Patients	221	18
19	Laboratory	1,719	19
20	Radiology and X-Ray	724	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 70,361	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	791	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 791	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Misc. Income**	289	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 289	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,200,413	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	488,920	31
32	Health Care	1,314,802	32
33	General Administration	618,269	33
	B. Capital Expense		
34	Ownership	213,744	34
	C. Ancillary Expense		
35	Special Cost Centers	75,871	35
36	Provider Participation Fee	140,071	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,851,677	40
41	**Income before Income Taxes (line 30 minus line 40)****	348,736	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 348,736	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 965,770	44
45	Private Pay - Net Inpatient Revenue	963,435	45
46	Medicare - Net Inpatient Revenue	553,819	46
47	Other-(specify) **Managed Care - Net Inpatient Revenue**	31,299	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,514,323	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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: 1/1/2018 Ending: 12/31/2018

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	2,054	2,094	$ 69,247	$ 33.07	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,045	10,680	260,556	24.40	3
4	Licensed Practical Nurses	5,186	5,342	115,760	21.67	4
5	CNAs & Orderlies	31,694	32,785	378,793	11.55	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,485	1,524	16,117	10.58	9
10	Activity Assistants					10
11	Social Service Workers	1,833	2,005	27,650	13.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	8,898	9,431	110,599	11.73	15
16	Dishwashers					16
17	Maintenance Workers	2,396	2,595	46,762	18.02	17
18	Housekeepers	5,118	5,305	46,331	8.73	18
19	Laundry	3,168	3,359	29,725	8.85	19
20	Administrator	1,688	1,688	73,241	43.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,982	3,403	66,049	19.41	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	88	88	848	9.64	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	345	345	4,261	12.35	33
34	TOTAL (lines 1 - 33)	76,980	80,644	$ 1,245,939 *	$ 15.45	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	88	$ 2,436	1-3	35
36	Medical Director	48	11,000	9-3	36
37	Medical Records Consultant	36	1,689	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	14	4,050	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	25	1,641	11-3	44
45	Social Service Consultant	25	1,641	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	236	$ 22,457		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: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Paula Schoonover	Administrator		$ 73,241
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 73,241

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
Bradley Associates	Accounting	$ 2,028
Parrish Consulting Services, Inc.	Technology	8,746
Integrated Resources Mgmt.	Payroll	36,296
Ide Management Group	Professional/Mgmt.	60,000
Weber, Tedford, Heap & Ayres	Legal	500
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 107,570

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,210
Unemployment Compensation Insurance	17,094
FICA Taxes	92,525
Employee Health Insurance	97,779
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	860
Employee Physicals	120
Human Resources	3,862
Ide Management Group	19,354
TOTAL (agree to Schedule V, line 22, col.8)	$ 276,804

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)	
Patient Background Checks	
Illinois Dept. of HFS - 2 yr facility license fee	3,980
Jasper County Health Department	50
Southeastern IL Activity Dir. Association	10
IL Nursing Home Administrators Assoc.	100
Various	503
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,643

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Mileage	3,153
Parking	49
Seminar Expense	
Education	300
Hotel	332
Ide Management Group	8,419
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,253

* Attach copy of IMRF notifications

**See instructions.

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 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,833** 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. $ **140,071**
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. $ **N/A**
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? **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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees