		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.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0024984

Facility Name: Newton Rest Haven

Address: 300 S Scott Street, PO Box 360 (Number) Newton (City) 62448 (Zip Code)

County: Jasper

Telephone Number: (618) 783-2309 **Fax #** (618) 783-2732

HFS ID Number:

Date of Initial License for Current Owners: 1969

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/2010 to 6/30/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Karen Kinder
(Title) Administrator/Owner

Paid Preparer
(Signed) Accountants Compilation Report Attached (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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	82	Skilled (SNF)	82	29,930	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	82	TOTALS	82	29,930	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	8,890	6,945	1,902	17,737	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,890	6,945	1,902	17,737	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.26%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care and Outpatient Therapy

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/01/1969

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/19/1984 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 1,902

Medicare Intermediary National Government Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2011 Fiscal Year: 6/30/2011

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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	119,087	261	1,584	120,932		120,932	(138)	120,794			1
2	Food Purchase		152,241		152,241		152,241	(115)	152,126			2
3	Housekeeping	42,698	3,787		46,485		46,485	(200)	46,285			3
4	Laundry	28,399	996		29,395		29,395		29,395			4
5	Heat and Other Utilities			77,948	77,948		77,948	(5,020)	72,928			5
6	Maintenance	85,731		35,195	120,926		120,926		120,926			6
7	Other (specify):* Medical Waste			13,094	13,094		13,094		13,094			7
8	TOTAL General Services	275,915	157,285	127,821	561,021		561,021	(5,473)	555,548			8
	B. Health Care and Programs											
9	Medical Director			10,200	10,200		10,200		10,200			9
10	Nursing and Medical Records	772,336	57,295	3,314	832,945		832,945	(3,198)	829,747			10
10a	Therapy			240,265	240,265		240,265		240,265			10a
11	Activities	13,963	1,887	1,610	17,460		17,460		17,460			11
12	Social Services	22,612		1,610	24,222		24,222		24,222			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	808,911	59,182	256,999	1,125,092		1,125,092	(3,198)	1,121,894			16
	C. General Administration											
17	Administrative	47,727			47,727		47,727		47,727			17
18	Directors Fees											18
19	Professional Services			25,864	25,864		25,864		25,864			19
20	Dues, Fees, Subscriptions & Promotions			20,846	20,846		20,846	(10,227)	10,619			20
21	Clerical & General Office Expenses	63,423	18,564	19,313	101,300		101,300	(1,738)	99,562			21
22	Employee Benefits & Payroll Taxes			245,349	245,349		245,349	(31,735)	213,614			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,956	6,956		6,956	(5,009)	1,947			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			44,239	44,239		44,239	(300)	43,939			26
27	Other (specify):*											27
28	TOTAL General Administration	111,150	18,564	362,567	492,281		492,281	(49,009)	443,272			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,195,976	235,031	747,387	2,178,394		2,178,394	(57,680)	2,120,714			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Newton Rest Haven #0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			11,758	11,758		11,758		11,758			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,915	12,915		12,915	(12,620)	295			32
33	Real Estate Taxes			23,286	23,286		23,286		23,286			33
34	Rent-Facility & Grounds			61,000	61,000		61,000	(61,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Income Taxes			33,808	33,808		33,808	(33,808)				36
37	**TOTAL Ownership**			142,767	142,767		142,767	(107,428)	35,339			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,944	12,818	88,762		88,762		88,762			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,895	44,895		44,895		44,895			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		75,944	57,713	133,657		133,657		133,657			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,195,976	310,975	947,867	2,454,818		2,454,818	(165,108)	2,289,710			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$ (3,198)	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(115)	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	(12,620)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,738)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,006)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(31,735)	22		15
16	Personal Expenses (Including Transportation)	(4,239)	24		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(925)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(6,350)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(33,808)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,374)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (104,108)		$	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)	(61,000)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (61,000)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (165,108)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Newton Rest Haven

ID# 0024984

Report Period Beginning: 7/01/2010

Ending: 6/30/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate PAC dues, inlcuding Lobbying poriton	$ (1,941)	20	1
2	Add back 2011 IDPH license paid in 2010	995	20	2
3	Offset Housekeeping Rebate	(200)	3	3
4	Offset Dietary Rebate	(138)	1	4
5	Offset Seminar & Books Reimbursement	(770)	24	5
6	Offset Cable Reimbursement	(5,020)	5	6
7	Offset State Farm Ins Refunds	(300)	26	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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**	(7,374)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newton Rest Haven **#** 0024984 **Report Period Beginning:** 7/01/2010 **Ending:** 6/30/2011

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	(138)	0	0	0	0	0	0	0	0	0	0	(138)	1
2	Food Purchase	(115)	0	0	0	0	0	0	0	0	0	0	(115)	2
3	Housekeeping	(200)	0	0	0	0	0	0	0	0	0	0	(200)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,020)	0	0	0	0	0	0	0	0	0	0	(5,020)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,473)	0	0	0	0	0	0	0	0	0	0	(5,473)	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	(3,198)	0	0	0	0	0	0	0	0	0	0	(3,198)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,198)	0	0	0	0	0	0	0	0	0	0	(3,198)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(10,227)	0	0	0	0	0	0	0	0	0	0	(10,227)	20
21	Clerical & General Office Expenses	(1,738)	0	0	0	0	0	0	0	0	0	0	(1,738)	21
22	Employee Benefits & Payroll Taxes	(31,735)	0	0	0	0	0	0	0	0	0	0	(31,735)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,009)	0	0	0	0	0	0	0	0	0	0	(5,009)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(300)	0	0	0	0	0	0	0	0	0	0	(300)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(49,009)	0	0	0	0	0	0	0	0	0	0	(49,009)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(57,680)	0	0	0	0	0	0	0	0	0	0	(57,680)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newton Rest Haven # 0024984 **Report Period Beginning:** 7/01/2010 **Ending:** 6/30/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,620)	0	0	0	0	0	0	0	0	0	0	(12,620)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(61,000)	0	0	0	0	0	0	0	0	0	(61,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(33,808)	0	0	0	0	0	0	0	0	0	0	(33,808)	36
37	**TOTAL Ownership**	(46,428)	(61,000)	0	0	0	0	0	0	0	0	0	(107,428)	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)**	(104,108)	(61,000)	0	0	0	0	0	0	0	0	0	(165,108)	45

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Karen Kinder	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Building Rent	$ 61,000	Karen Kinder	100.00%	$	$ (61,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 61,000			$	$ * (61,000)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Karen Kinder	Administrator	Administrator	100.00		40	100.00	Salary	$ 47,727	17,1	1
2	Roger Kinder	Maintenance Supervi	Maintenance Super	0.00		40	100.00	Salary	48,000	6,1	2
3	Kathryn Augustyn	Clerical	Clerical	0.00		40	100.00	Salary	15,125	21,1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 110,852		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Schedule Not Applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Peoples State Bank		X		Various	4/30/99	$ 658,599	$	10/11/10	5.5000	$ 126	1
2	Peoples State Bank		X		Various	6/09	150,000	1	10/8/11	5.2500	7,025	2
3	Peoples State Bank		X		Various	10/8/10	150,000	79,171	10/15	5.2500	4,171	3
4												4
5												5
	Working Capital											
6	PNC Bank		X	Line of Credit	Various	6/09			N/A	min. 3%	1,374	6
7	HP Financial Services		X	Computer Hardware	$314.64	9/14/09	6,985	932	9/14/11	7.5990	219	7
8									Interest Income Offset		(12,620)	8
9	TOTAL Facility Related				$314.64		$ 965,584	$ 80,104			$ 295	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 965,584	$ 80,104			$ 295	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	34,200	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.)	$	22,786	2
3. Under or (over) accrual (line 2 minus line 1).	$	(11,414)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,700	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.	$	23,286	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	22,027	8
	2007	21,535	9
	2008	21,830	10
	2009	22,786	11
	2010	23,108	12

Line 2 : 2009 Taxes paid

Line 4: Accrual is based on 2009 tax bill plus half estimated 2010 tax bill for 1/1/11 - 6/30/11

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Newton Rest Haven COUNTY Jasper

FACILITY IDPH LICENSE NUMBER 0024984

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	90-13-06-106-008	S PT NW 1/4	$ 22,551.48	$ 22,551.48
2.	90-13-06-300-027	N PT N 1/2 SW 1/4	$ 246.74	$ 246.74
3.	90-13-06-106-006	1.15 AC S PT NW 1/4	$ 254.78	$ 254.78
4.	90-13-06-300-003	PT OF N 1/2 SW 1/4	$ 55.46	$ 55.46
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,108.46	$ 23,108.46

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,849 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		320,166	1969	$ 23,827	1
2					2
3	TOTALS	320,166		$ 23,827	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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	82		1969	1969	$ 449,793	$	30	$	$	$ 449,793	4
5			1969	1969	255,492		30				5
6											6
7											7
8											8
	Improvement Type**										
9	Nurses Station			1974	1,040		10			1,040	9
10	Landscaping			1976	3,786		10			3,786	10
11	Driveway			1979	1,187		15			1,187	11
12	Alarm System			1983	2,100		15			2,100	12
13	Flooring, Roof, and Ceiling			1984	31,689		15-18			31,689	13
14	Insulation, Utility Building, and Flooring			1985	16,758		19			16,758	14
15	Dampers and Wallpaper			1986	6,251		5-19			6,251	15
16	Flooring & Sidewalks			1987	5,257	162	10-31	162		4,160	16
17	Wallpaper			1988	9,153	296	31	296		6,667	17
18	Wallpaper and Water Heaters			1990	8,366	269	31	269		5,555	18
19	Soffit			1991	3,012	97	31	97		1,943	19
20	Water Heaters			1995	1,870	60	31	60		970	20
21	Stove			1996	3,510	90	39	90		1,395	21
22	Hot Water Heater			1996	2,572	66	39	66		1,017	22
23	Concrete Sealing			1996	2,239	57	39	57		851	23
24	Boiler			1997	2,465	63	39	63		911	24
25	Painting			1997	1,788	46	39	46		646	25
26	Fixed Equipment			1998	4,188		5			4,188	26
27	Electrical Shut Off Box			2003	1,130	113	10	113		914	27
28	Painting			2002	979	98	10	98		857	28
29	Plastering			2002	7,560	756	10	756		6,678	29
30	Awning			2002	963	64	15	64		567	30
31	Gutters			2002	3,619	241	15	241		2,152	31
32	Phone System			2004	956	64	15	64		451	32
33	Fire Alarm System			2004	5,260	351	15	351		2,484	33
34	Landscaping			2006	1,146	229	5	229		1,089	34
35	Tile			2006	10,558	705	15	705		3,285	35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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)		$ 844,687	$ 3,827		$ 3,827	$	$ 559,384	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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	$ 64,773	$ 7,602	$ 7,602	$	5-15 yrs	$ 36,500	71
72	Current Year Purchases	1,662	59	59		10 yrs.	59	72
73	Fully Depreciated Assets	153,498	245	245		5-10 yrs.	153,498	73
74								74
75	TOTALS	$ 219,933	$ 7,906	$ 7,906	$		$ 190,057	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Faculty Business	Ford E350 Van	2001	$ 15,080	$	$	$	5	$ 15,080	76
77	Faculty Business	Trailer	1985	560				5	560	77
78	Faculty Business	Shop Truck	1998	1,000				5	1,000	78
79	Faculty Business	2004 Dodge Dakota Quad Cab	2011	1,500	25	25		5	25	79
80	TOTALS			$ 18,140	$ 25	$ 25	$		$ 16,665	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)	$ 1,106,587	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 11,758	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 11,758	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)	$ 766,106	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Schedule Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

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, 8	1660	hrs	$ 90,863		$	$	1,660	$ 90,863	1
2	Licensed Speech and Language Development Therapist	10a, 8	788	hrs	35,460				788	35,460	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a, 8	2682	hrs	113,942				2,682	113,942	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				75,944		75,944	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Lab Fees & X-Rays	39,3					12,818			12,818	12
13	Other (specify):										13
14	TOTAL				$ 240,265		$ 12,818	$ 75,944	5,130	$ 329,027	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2011 (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	$ 97,263	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	115,896		3
4	Supply Inventory (priced at)	23,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,110		6
7	Other Prepaid Expenses	6,086		7
8	Accounts Receivable (owners or related parties)	379,026		8
9	Other(specify): Employee Loans	2,707		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 639,088	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	23,827		13
14	Buildings, at Historical Cost	449,793		14
15	Leasehold Improvements, at Historical Cost	139,403		15
16	Equipment, at Historical Cost	238,073		16
17	Accumulated Depreciation (book methods)	(766,106)		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)**	$ 84,990	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 724,078	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 62,410	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,043		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,700		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	416		35
	Other Current Liabilities(specify):			
36	Lease Payable	932		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 160,501	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	79,172		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)**	$ 79,172	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 239,673	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 484,405	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 724,078	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Newton Rest Haven **#** 0024984 **Report Period Beginning:** 7/01/2010 **Ending:** 6/30/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 417,745	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 417,745	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	86,660	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	(20,000)	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)**	$ 66,660	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)**	$ 484,405	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,116,477	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,116,477	3
	B. Ancillary Revenue		
4	Day Care	3,198	4
5	Other Care for Outpatients		5
6	Therapy	351,345	6
7	Oxygen	4,694	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 359,237	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,375	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,375	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,620	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,620	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income & Rebates/Refunds	50,769	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 50,769	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,541,478	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	561,021	31
32	Health Care	1,125,092	32
33	General Administration	492,281	33
	B. Capital Expense		
34	Ownership	142,767	34
	C. Ancillary Expense		
35	Special Cost Centers	88,762	35
36	Provider Participation Fee	44,895	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,454,818	40
41	**Income before Income Taxes (line 30 minus line 40)****	86,660	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 86,660	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

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

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

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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	2,006	2,122	$ 52,750	$ 24.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,868	12,169	230,289	18.92	3
4	Licensed Practical Nurses	8,126	8,451	141,767	16.78	4
5	CNAs & Orderlies	33,401	34,075	300,983	8.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,460	1,460	13,963	9.56	9
10	Activity Assistants					10
11	Social Service Workers	1,795	1,984	22,612	11.40	11
12	Dietician	13,363	13,617	119,086	8.75	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,507	3,669	85,731	23.37	17
18	Housekeepers	4,873	4,988	42,698	8.56	18
19	Laundry	3,311	3,311	28,399	8.58	19
20	Administrator	1,760	2,100	47,727	22.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,573	3,999	63,423	15.86	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	1,980	2,080	22,637	10.88	31
32	Other Health Care(specify)					32
33	Other(specify) Unit Assistants	2,256	2,256	23,911	10.60	33
34	TOTAL (lines 1 - 33)	93,279	96,281	$ 1,195,976 *	$ 12.42	34

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	44	$ 1,584	1,3	35
36	Medical Director	Contract	10,200	9,3	36
37	Medical Records Consultant	16	1,125	10,3	37
38	Nurse Consultant	64	1,920	10,3	38
39	Pharmacist Consultant	16	270	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,610	11,3	44
45	Social Service Consultant	25	1,610	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	190	$ 18,319		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Kinder	Administrator	100	$ 47,727
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 47,727

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
LuAllen, Cearlock, Barth & Burnam	Accounting Fees	$ 15,050
Oldfield Law Group	Legal Fees	164
Automatic Data Processing	Payroll Service	10,600
Jasper County Recorder	Legal Fees	50
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 25,864

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,012
Unemployment Compensation Insurance	15,202
FICA Taxes	91,492
Employee Health Insurance	28,535
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	11,054
Life Insurance	319
TOTAL (agree to Schedule V, line 22, col.8)	$ 213,614

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	$ 995
Advertising: Employee Recruitment	3,635
Health Care Worker Background Check (Indicate # of checks performed 101)	2,020
Patient Background Checks	
Bank Service Charges	25
Dues & Subscriptions	3,413
Licenses & Fees	531
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,619

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	40
Seminar Expense	1,907
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,947

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/01/2010 Ending: 6/30/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $2,979**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **473** 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 fo 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 Departmen during this cost report period. $ **44,895**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed tc the Department, in addition to the daily rate, been properly classifiec 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 fo the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **115**

(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 fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe 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 out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

NEWTON REST HAVEN
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
6/30/2011

Miscellaneous Income	206.30
Prior Period Medicare Settlement	42,232.00
Admit Fee	50.00
W. Eyman Cell Phone Reimb.	589.28
Miscellaneous Rebates & Refunds	1,466.50
Postage	19.71
Meals Reimb	115.00
Seminar and books Reimb.	770.00
Utilities-Cable	5,020.00
State Farm Ins Refund	300.00
	50,768.79

Newton Rest Haven
Attachment to Sch. XVII
June 30, 2011

BOOK TO TAX NET INCOME RECONCILIATION

BOOK NET INCOME (LOSS)	$ 86,660.00
DEPRECIATION ADJUSTMENT	4,477.00
FEDERAL INCOME TAX EXPENSE - NON-DEDUCTIBLE	27,914.00
FEDERAL INCOME TAX REFUND	(4,522.00)
ROUNDING DIFFERENCE	(5.00)
TAX NET INCOME (LOSS), PER FEDERAL RETURN	$ 114,524.00