

Facility Name & ID Number Newton Rest Haven

0024984 Report Period Beginning: 7/1/03 Ending: 6/30/04

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>92</u>	Skilled (SNF)	<u>92</u>	<u>33,672</u>	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	<u>92</u>	TOTALS	<u>92</u>	<u>33,672</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>235</u>		<u>2,400</u>	<u>2,635</u>	8
9	SNF/PED					9
10	ICF	<u>11,164</u>	<u>7,697</u>		<u>18,861</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,399</u>	<u>7,697</u>	<u>2,400</u>	<u>21,496</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.84%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 8/1/1969

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

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

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/04 Fiscal Year: 6/30/04

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

STATE OF ILLINOIS

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/1/03 Ending: 6/30/04

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	81,360	3,330	1,728	86,418		86,418		86,418		1
2	Food Purchase		133,769		133,769		133,769	(7,914)	125,855		2
3	Housekeeping	36,447		12,240	48,687		48,687		48,687		3
4	Laundry	29,703	6,411	1,436	37,550		37,550	(82)	37,468		4
5	Heat and Other Utilities			83,949	83,949		83,949	(3,220)	80,729		5
6	Maintenance	85,530	39,971		125,501		125,501	(1,038)	124,463		6
7	Other (specify):*										7
8	TOTAL General Services	233,040	183,481	99,353	515,874		515,874	(12,254)	503,620		8
B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800		9
10	Nursing and Medical Records	696,176	102,872	18,632	817,680	(74,135)	743,545	(9,083)	734,462		10
10a	Therapy			248,385	248,385		248,385		248,385		10a
11	Activities	16,645	4,710		21,355		21,355		21,355		11
12	Social Services	18,712		1,725	20,437		20,437		20,437		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	731,533	107,582	270,542	1,109,657	(74,135)	1,035,522	(9,083)	1,026,439		16
C. General Administration											
17	Administrative	164,664			164,664		164,664		164,664		17
18	Directors Fees										18
19	Professional Services			25,375	25,375		25,375		25,375		19
20	Dues, Fees, Subscriptions & Promotions			60,411	60,411		60,411		60,411		20
21	Clerical & General Office Expenses	40,522	8,689	85,521	134,732		134,732	(33,166)	101,566		21
22	Employee Benefits & Payroll Taxes			150,698	179,522		179,522	(1,920)	177,602		22
23	Inservice Training & Education										23
24	Travel and Seminar			12,248	12,248		12,248		12,248		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			62,461	62,461		62,461		62,461		26
27	Other (specify):*			357	357		357		357		27
28	TOTAL General Administration	205,186	8,689	397,071	639,770		639,770	(35,086)	604,684		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,169,759	299,752	766,966	2,265,301	(74,135)	2,191,166	(56,423)	2,134,743		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 Rest Haven

#0024984

Report Period Beginning:

7/1/03

Ending:

6/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			21,059	21,059		21,059	7,729	28,788			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			50,925	50,925		50,925		50,925			32
33	Real Estate Taxes			32,721	32,721		32,721		32,721			33
34	Rent-Facility & Grounds			51,600	51,600		51,600	(51,600)				34
35	Rent-Equipment & Vehicles			5,880	5,880		5,880		5,880			35
36	Other (specify):*											36
37	TOTAL Ownership			162,185	162,185		162,185	(43,871)	118,314			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					74,135	74,135	(71)	74,064			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					74,135	74,135	(71)	74,064			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,169,759	299,752	929,151	2,427,486		2,427,486	(100,365)	2,327,121			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 Rest Haven

0024984

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$ (38)	10-3	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,753)	2-3		4
5	Telephone, TV & Radio in Resident Rooms	(3,220)	6-3		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(82)	4-3		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,743)	21-3		10
11	Discounts, Allowances, Rebates & Refunds	(9,966)	21-3		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,249)	21-3		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				18
19	Entertainment				19
20	Contributions	(3,912)	27-3		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	(15,000)	20-3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Various</u>	(12,531)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (56,494)		\$	30

OHF 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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(43,871)	34-3	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (43,871)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (100,365)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.			\$	38
39	<u>PT, OT, ST</u>				39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs			66,529	10-2
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule <u>Supplies</u>			7,606	10-2
47	TOTAL (C): (sum of lines 38-46)			\$ 74,135	47

Newton Rest Haven

ID# 0024984
 Report Period Beginning: 7/1/03
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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Repairs & Maint Income	\$ (1,038)	6-3	1
2				2
3				3
4	Copies Revenue	(288)	21-3	4
5	Dietary Rebates	(12)	2-3	5
6	Lab Refund	(71)	39-3	6
7	Dietary Refund	(149)	2-3	7
8	Drugs Refund	(1,392)	10-3	8
9	Admission Fee	(200)	10-3	9
10	Employee Loans	(1,920)	22-3	10
11	Med supply Income	(5,056)	10-3	11
12	Oxygen Income	(2,397)	10-3	12
13	Postage Income	(7)	21-3	13
14	Phone Income	(1)	21-3	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	(12,531)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Building Rent	\$ 51,600	Karen Kinder	100.00%	\$	\$(51,600)	1
2	V	30 Depreciation		Karen Kinder	100.00%	7,729	7,729	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		\$ 51,600			\$ 7,729	\$ * (43,871)	14

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

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/1/03 Ending: 6/30/04

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Karen Kinder	Administrator	Administrator	100.00	N/A	40	100.00	Salary	\$ 164,664	17-1	1
2	Roger Kinder	Main Super	Main Super		N/A	40	100.00	Salary	48,000	1-Jun	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 212,664		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 Rest Haven # 0024984 Report Period Beginning: 7/1/03 Ending: 6/30/04

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

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

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

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					\$	\$			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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Peoples State Bank		X	Van	\$368.17	11/1/01	\$ 15,080	\$	10/02/05	8.0000	\$ 305	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	Peoples State Bank		X	LOC	Various	3/24/04		797,685		7.0000	50,620	6								
7												7								
8												8								
9	TOTAL Facility Related				\$368.17		\$ 15,080	\$ 797,685			\$ 50,925	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 15,080	\$ 797,685			\$ 50,925	15								

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

* 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.)

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2003 report.			\$	31,638	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.)			\$	20,746	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(10,892)	3
4.	Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	43,613	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.			\$	32,721	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		1999	17,996	8		
		2000	17,667	9		
		2001	17,258	10		
		2002	18,780	11		
		2003	20,746	12		
					FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2003	\$		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Newton Rest Haven COUNTY Jasper

FACILITY IDPH LICENSE NUMBER 0024984

CONTACT PERSON REGARDING THIS REPORT Lisa Deaton

TELEPHONE 317-633-4705 ext 361 FAX #: 317-633-4889

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 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 2003.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>90-13-06-300-027</u>	<u></u>	\$ <u>175.72</u>	\$ <u>175.72</u>
2. <u>90-13-06-300-003</u>	<u></u>	\$ <u>46.26</u>	\$ <u>46.26</u>
3. <u>90-13-06-106-006</u>	<u></u>	\$ <u>181.20</u>	\$ <u>181.20</u>
4. <u>90-13-06-106-008</u>	<u></u>	\$ <u>20,676.92</u>	\$ <u>20,676.92</u>
5. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10. <u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS		\$ <u>21,080.10</u>	\$ <u>21,080.10</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & 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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Newton Rest Haven

0024984 Report Period Beginning:

7/1/03 Ending:

6/30/04

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

1. Total Amount Incurred: _____ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1969	\$ 23,827	1
2					2
3	TOTALS			\$ 23,827	3

Facility Name & ID Number Newton Rest Haven

0024984

Report Period Beginning:

7/1/03

Ending:

6/30/04

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	92	1969	1969	\$ 449,793	\$ 5,259	30			\$ 449,793	4
5		1969	1969	255,492		30	7,729	7,729	227,036	5
6										6
7										7
8										8
Improvement Type**										
9	Various		1974	1,040		19			1,040	9
10	Various		1976	3,786		19			3,786	10
11	Various		1979	1,187		19			1,187	11
12	Various		1983	2,100		19			2,100	12
13	Various		1984	31,689	1,053	18	1,053		31,689	13
14	Various		1985	16,758	487	19	487		16,086	14
15	Various		1986	6,251	113	19	113		6,194	15
16	Various		1987	5,257	202	31	202		3,023	16
17	Various		1988	9,153		31			9,153	17
18	Various		1990	8,366		31			8,366	18
19	Various		1991	3,012	97	31	97		2,306	19
20	Various		1995	1,870	88	31	88		548	20
21	Stove		1996	3,510	109	39	109		765	21
22	Hot Water Heater		1996	2,572	68	39	68		555	22
23	Concrete Sealing		1996	2,239	61	39	61		450	23
24	Boiler		1997	2,465	66	39	66		469	24
25	Painting		1997	1,788	96	39	96		325	25
26	Fixed Equipment		1998	4,188		39			4,188	26
27	Electrical Shut off Box		2003	1,130	9	10	9		122	27
28	Painting		2002	979	73	10	73		171	28
29	Plastering		2002	7,560	630	10	630		1,386	29
30	Awning		2002	963	53	15	53		118	30
31	Gutters		2002	3,619	221	15	221		462	31
32	Phone System		2004	956	5	15	5		5	32
33	Fire Alarm System		2004	5,260	29	15	29		29	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 Rest Haven

0024984

Report Period Beginning:

7/1/03

Ending:

6/30/04

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 832,983	\$ 8,719		\$ 11,189	\$ 7,729	\$ 771,352		70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 55,985	\$ 6,142	\$ 6,142	\$		\$ 41,416	71
72	Current Year Purchases	29,476	791	791			791	72
73	Fully Depreciated Assets	240,294					240,294	73
74								74
75	TOTALS	\$ 325,755	\$ 6,933	\$ 6,933	\$		\$ 282,501	75

D. Vehicle Depreciation (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	Facility Business	Van	1989 - 2001	\$ 60,866	\$ 4,021	\$ 4,021	\$	5	\$ 54,331	76
77	Facility Business	Trailer	1985	560				5	560	77
78	Facility Business	New Trucks	2004	40,455	1,349	1,349		5	1,349	78
79	Facility Business	Shop Truck	1998	1,000					1,000	79
80	TOTALS			\$ 102,881	\$ 5,370	\$ 5,370	\$		\$ 57,240	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)	\$ 1,285,446	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 21,022	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,492	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,470	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,111,093	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			N/A		88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94		N/A	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.

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

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.	<u>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</u>	\$ _____

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES 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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Units	Cost						
					Units	Cost								
1	Licensed Occupational Therapist	10A-3	hrs	\$	270	\$ 14,853						270	\$ 14,853	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		432	19,418						432	19,418	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10A-3	hrs		158	8,663						158	8,663	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39-3	# of prescripts							66,529			66,529	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify): Speech Therapy/Lab													13
14	TOTAL			\$	860	\$ 42,934				\$ 66,529		860	\$ 109,463	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Newton Rest Haven

0024984

Report Period Beginning: 7/1/03

Ending:

6/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/04

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 500,533	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	191,619		3
4 Supply Inventory (priced at Cost)	23,000		4
5 Short-Term Investments			5
6 Prepaid Insurance	5,333		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)	122,713		8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 843,198	\$	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	127,699		15
16 Equipment, at Historical Cost	428,636		16
17 Accumulated Depreciation (book methods)	(884,066)		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): Related Party LT	331,117		23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 477,006	\$	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,320,204	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 103,810	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	64,820		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)	43,613		32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 212,243	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	797,685		39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 797,685	\$	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,009,928	\$	46
47 TOTAL EQUITY (page 18, line 24)	\$ 310,276	\$	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,320,204	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,852)	1
2	Restatements (describe):		2
3	Diff between 03 Equity and 04 Retained Earnings	(211)	3
4	Balance Adjustments	(42,135)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (45,198)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	355,474	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 355,474	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)	\$ 310,276	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,067,488	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,067,488	3
B. Ancillary Revenue			
4	Day Care	38	4
5	Other Care for Outpatients		5
6	Therapy	559,819	6
7	Oxygen	7,885	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 567,742	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	28	13
14	Non-Patient Meals	7,886	14
15	Telephone, Television and Radio	3,221	15
16	Rental of Facility Space		16
17	Sale of Drugs	107,909	17
18	Sale of Supplies to Non-Patients	17,531	18
19	Laboratory	5,521	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	82	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 142,178	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,743	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,743	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	3,809	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,809	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,782,960	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	515,874	31
32	Health Care	1,106,328	32
33	General Administration	526,801	33
B. Capital Expense			
34	Ownership	224,646	34
C. Ancillary Expense			
35	Special Cost Centers	3,329	35
36	Provider Participation Fee	50,508	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,427,486	40
41	Income before Income Taxes (line 30 minus line 40)**	355,474	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 355,474	43

* 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 Rest Haven**

0024984

Report Period Beginning: **7/1/03**

Ending:

6/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,898	2,029	\$ 40,862	\$ 20.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,046	6,484	109,327	16.86	3
4	Licensed Practical Nurses	13,300	15,057	213,563	14.18	4
5	Nurse Aides & Orderlies	33,604	35,624	314,660	8.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,094	2,188	16,645	7.61	10
11	Social Service Workers	1,764	1,926	18,712	9.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,587	11,835	81,360	6.87	15
16	Dishwashers					16
17	Maintenance Workers	3,504	4,201	85,530	20.36	17
18	Housekeepers	5,290	5,435	36,447	6.71	18
19	Laundry	4,129	4,388	29,703	6.77	19
20	Administrator	1,743	2,029	164,664	81.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,522	3,596	40,522	11.27	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	1,973	2,094	17,764	8.48	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,454	96,886	\$ 1,169,759 *	\$ 12.07	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	44	\$ 1,728	1.3	35
36	Medical Director				36
37	Medical Records Consultant	32	1,742	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	2,881	115,232	10a.3	40
41	Occupational Therapy Consultant	1,911	76,422	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	30	1,725	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,898	\$ 196,849		49

C. CONTRACT NURSES

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

