

Facility Name & ID Number Newton Rest Haven# 0024984 Report Period Beginning: 7/1/2005 Ending: 6/30/2006

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	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	12	Skilled (SNF)	12	4,380	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,200	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
		8	SNF			
9	SNF/PED					9
10	ICF	11,012	6,191	479	17,682	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,012	6,191	3,003	20,206	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.17%D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. 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 8/1/1969J. 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 2,222Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 6/30/2006 Fiscal Year: 6/30/2006

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

Facility Name & ID Number Newton Rest Haven # 0024984 Report Period Beginning: 7/1/2005 Ending: 6/30/2006**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	117,147	3,603	1,728	122,478		122,478		122,478		1
2	Food Purchase		122,469		122,469		122,469	(8,584)	113,885		2
3	Housekeeping	36,173	14,846		51,019		51,019		51,019		3
4	Laundry	29,943	11,826		41,769		41,769		41,769		4
5	Heat and Other Utilities			79,156	79,156		79,156		79,156		5
6	Maintenance	107,065		36,355	143,420		143,420		143,420		6
7	Other (specify):*										7
8	TOTAL General Services	290,328	152,744	117,239	560,311		560,311	(8,584)	551,727		8
B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	798,832	66,578	53,127	918,537	(66,578)	851,959		851,959		10
10a	Therapy			203,720	203,720		203,720		203,720		10a
11	Activities	19,994	2,826		22,820		22,820		22,820		11
12	Social Services	20,200		1,100	21,300		21,300		21,300		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	839,026	69,404	266,347	1,174,777	(66,578)	1,108,199		1,108,199		16
C. General Administration											
17	Administrative	149,046			149,046		149,046		149,046		17
18	Directors Fees										18
19	Professional Services			20,992	20,992		20,992		20,992		19
20	Dues, Fees, Subscriptions & Promotions			56,461	56,461	(50,370)	6,091		6,091		20
21	Clerical & General Office Expenses	58,835	21,360	67,588	147,783		147,783	(97,712)	50,071		21
22	Employee Benefits & Payroll Taxes			262,407	262,407		262,407		262,407		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,640	11,640		11,640		11,640		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*			82	82		82		82		27
28	TOTAL General Administration	207,881	21,360	419,170	648,411	(50,370)	598,041	(97,712)	500,329		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,337,235	243,508	802,756	2,383,499	(116,948)	2,266,551	(106,296)	2,160,255		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: 7/1/2005 Ending: 6/30/2006

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			21,426	21,426		21,426	5,229	26,655			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			83,061	83,061		83,061		83,061			32
33	Real Estate Taxes			22,065	22,065		22,065		22,065			33
34	Rent-Facility & Grounds			65,000	65,000		65,000	(65,000)				34
35	Rent-Equipment & Vehicles			5,261	5,261		5,261		5,261			35
36	Other (specify):*											36
37	TOTAL Ownership			196,813	196,813		196,813	(59,771)	137,042			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					66,578	66,578		66,578			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					50,370	50,370		50,370			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					116,948	116,948		116,948			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,337,235	243,508	999,569	2,580,312		2,580,312	(166,067)	2,414,245			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

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

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	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,584)	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	(1,962)	21		10
11	Discounts, Allowances, Rebates & Refunds	(187)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(1,976)	21		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				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,709)		\$	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	2	
		Amount	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)	(57,271)	21	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (57,271)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (69,980)		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						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs			58,653	10-2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule <u>Oxygen</u>			7,925	10-2	46
47	TOTAL (C): (sum of lines 38-46)			\$ 66,578		47

Newton Rest Haven

ID# 0024984

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Advertising	\$ (7,213)	21	1
2	Bank Charges	(82)	21	2
3	Gain on Sale of asset	(2,500)	30	3
4	Memorial Fund Income	(283)	21	4
5	Other Income	(28,738)	21	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				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	(38,816)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newton Rest Haven# 0024984

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,584)	0	0	0	0	0	0	0	0	0	0	(8,584)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	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	(8,584)	0	0	0	0	0	0	0	0	0	0	(8,584)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(97,712)	0	0	0	0	0	0	0	0	0	0	(97,712)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(97,712)	0	0	0	0	0	0	0	0	0	0	(97,712)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,296)	0	0	0	0	0	0	0	0	0	0	(106,296)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newton Rest Haven# 0024984

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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	(2,500)	7,729	0	0	0	0	0	0	0	0	0	5,229 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	(65,000)	0	0	0	0	0	0	0	0	0	(65,000) 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(2,500)	(57,271)	0	(59,771) 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
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(108,796)	(57,271)	0	(166,067) 45								

Facility Name & ID Number Newton Rest Haven

0024984

Report Period Beginning: 7/1/2005

Ending: 6/30/2006

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	\$ 65,000	Karen Kinder	100.00%	\$	\$(65,000)	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		\$ 65,000			\$ 7,729	\$ * (57,271)	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: 7/1/2005 Ending: 6/30/2006

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	0	40	100.00	Salary	\$ 149,046	17, 1	1
2	Roger Kinder	Main Super	Main Super	0.00	0	40	100.00	Salary	71,348	6, 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 220,394		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: 7/1/2005

Ending: 7/30/2006

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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

Facility Name & ID Number Newton Rest Haven# 0024984

Report Period Beginning:

7/1/2005

Ending:

6/30/2006

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	People State Bank		X	Mortgage	Various	04/30/99	\$ 658,599	\$ 434,205	10/11/2010	5.5000	\$ 24,245	1
2												2
3												3
4												4
5												5
	Working Capital											
6	People State Bank		X	Line of Credit	Various	03/03/06	150,000	13,001	03/03/07	7.2500		6
7												7
8												8
9	TOTAL Facility Related						\$ 808,599	\$ 447,206			\$ 24,245	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 808,599	\$ 447,206			\$ 24,245	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 2005 report.		\$ 22,065	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.)		\$ 22,065	2
3.	Under or (over) accrual (line 2 minus line 1).			3
4.	Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 22,166	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.		\$ 22,166	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2001	17,667	8	
	2002	18,780	9	
	2003	21,080	10	
	2004	22,065	11	
	2005	22,166	12	
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	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: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

2005 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 317-713-7921 FAX #: 317-713-7921

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>90-13-06-106-008</u>	<u></u>	\$ <u>21,741.88</u>	\$ <u>21,741.88</u>
2. <u>90-13-06-300-027</u>	<u></u>	\$ <u>184.76</u>	\$ <u>184.76</u>
3. <u>90-13-06-300-003</u>	<u></u>	\$ <u>48.66</u>	\$ <u>48.66</u>
4. <u>90-13-06-106-006</u>	<u></u>	\$ <u>190.54</u>	\$ <u>190.54</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>22,165.84</u>	\$ <u>22,165.84</u>

B. Real Estate Tax Cost Allocation:

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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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.

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 ground (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)

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:

7/1/2005

Ending:

6/30/2006

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 BHF 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	\$	30	\$	\$	\$ 449,793
5		1969	1969	255,492		30	7,729	7,729	
6									
7									
8									
Improvement Type**									
9	Various		1974	1,040		19			
10	Various		1976	3,786					
11	Various		1979	1,187					
12	Various		1983	2,100					
13	Various		1984	31,689					
14	Various		1985	16,758					
15	Various		1986	6,251	35			(35)	
16	Various		1987	5,257	162			(162)	
17	Various		1988	9,153	722			(722)	
18	Various		1990	8,366	269			(269)	
19	Various		1991	3,012	97			(97)	
20	Various		1995	1,870	60			(60)	
21	Stove		1996	3,510	90			(90)	
22	Hot Water Heater		1996	2,572	66			(66)	
23	Concrete Sealing		1996	2,239	57			(57)	
24	Boiler		1997	2,465	63			(63)	
25	Painting		1997	1,788	144			(144)	
26	Fixed Equip		1998	4,188					
27	Electrical Shut off Box		2003	1,130	113			(113)	
28	Painting		2002	979					
29	Plastering		2002	7,560	756			(756)	
30	Awning		2002	963	64			(64)	
31	Gutters		2002	3,619	241			(241)	
32	Phone System		2004	956	64			(64)	
33	Fire Alarm System		2004	5,260	351			(351)	
34									
35									
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

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	\$ 3,354		\$ 7,729	\$ 4,375	\$ 449,793		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	\$ 60,715	\$	\$	\$		\$	71
72	Current Year Purchases	6,894						72
73	Fully Depreciated Assets	270,218						73
74								74
75	TOTALS	\$ 337,827	\$	\$	\$		\$	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	1993-2001	\$ 45,105	\$ 3,016	\$ 3,016	\$		\$ 44,602	76
77	Facility Business	Trailer	1985	560					560	77
78	Facility Business	Truck	2004	40,455	8,091	8,091			17,531	78
79	Facility Business	Shop Truck	1998	1,000					1,000	79
80	TOTALS			\$ 87,120	\$ 11,107	\$ 11,107	\$		\$ 63,693	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)	\$ 1,281,757	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,461	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 18,836	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,375	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 513,486	85

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

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

G. Construction-in-Progress

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

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

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

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? YES NO
If NO, see instructions.

		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. _____/2007 \$ _____
13. _____/2008 \$ _____
14. _____/2009 \$ _____

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.

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.)

<p>1. HAVE YOU TRAINED CNAs 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 CNA _____</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 CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1 Drop-outs	2 Completed	3 Contract	
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)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost	Units	Cost				
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	10A-3	hrs	\$	1,691	\$ 81,040						1,691	\$ 81,040	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		559	25,166						559	25,166	2
3	Licensed Recreational Therapist		hrs											3
4	Licensed Physical Therapist	10A-3	hrs		2,347	97,514						2,347	97,514	4
5	Physician Care		visits											5
6	Dental Care		visits											6
7	Work Related Program		hrs											7
8	Habilitation		hrs											8
9	Pharmacy	39-5	# of prescripts							58,653			58,653	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs											10
11	Academic Education		hrs											11
12	Exceptional Care Program													12
13	Other (specify):													13
14	TOTAL			\$	4,597	\$ 203,720				\$ 58,653		4,597	\$ 262,373	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Newton Rest Haven

0024984

Report Period Beginning: 7/1/2005

Ending:

6/30/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2006

(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	\$ 2,428	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	481,487		3
4	Supply Inventory (priced at)	23,000		4
5	Short-Term Investments			5
6	Prepaid Insurance	10,444		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 517,359	\$	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	425,047		16
17	Accumulated Depreciation (book methods)	(899,930)		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	340,667		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 467,103	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 984,462	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 58,413	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,220		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,049		31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,065		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	LOC	13,001		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 165,748	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	434,205		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)	\$ 434,205	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 599,953	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 384,509	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 984,462	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 280,830	1
2	Restatements (describe):	(10,000)	2
3	Diff in 05 & 06 RE		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 270,830	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	103,678	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	25,000	9
10	Stock Options Exercised	(15,000)	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)	\$ 113,678	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)	\$ 384,508	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number Newton Rest Haven# 0024984Report Period Beginning: 7/1/2005Page 19
Ending: 6/30/2006

VII. 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	\$ 2,019,663	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,019,663	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	458,976	6
7	Oxygen	8,789	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 467,765	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	8,584	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	128,645	17
18	Sale of Supplies to Non-Patients	17,603	18
19	Laboratory	8,062	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 162,894	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,962	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,962	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	31,423	28
28a	Memorial Fund	283	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 31,706	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,683,990	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	936,328	31
32	Health Care	918,537	32
33	General Administration	550,699	33
B. Capital Expense			
34	Ownership	174,748	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,580,312	40
41	Income before Income Taxes (line 30 minus line 40)**	103,678	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 103,678	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: **7/1/2005**Ending: **6/30/2006****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	1,624	1,624	\$ 43,586	\$ 26.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,209	7,329	122,336	16.69	3
4	Licensed Practical Nurses	16,301	17,437	259,357	14.87	4
5	CNAs & Orderlies	40,509	41,328	355,492	8.60	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,570	2,630	19,994	7.60	10
11	Social Service Workers	1,906	2,106	20,200	9.59	11
12	Dietician					12
13	Food Service Supervisor	15,744	16,398	117,147	7.14	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,384	4,384	107,065	24.42	17
18	Housekeepers	5,249	5,293	36,173	6.83	18
19	Laundry	3,969	4,904	29,943	6.11	19
20	Administrator	2,032	2,032	149,046	73.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,052	4,108	58,835	14.32	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	2,025	2,145	18,061	8.42	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	107,574	111,718	\$ 1,337,235 *	\$ 11.97	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	96	\$ 1,728	1.3	35
36	Medical Director				36
37	Medical Records Consultant	29	1,680	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	31	1,483	10.3	39
40	Physical Therapy Consultant	2,347	97,514	10a.3	40
41	Occupational Therapy Consultant	50,064	81,040	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	559	25,166	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	17	1,100	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	53,143	\$ 209,711		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	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

Facility Name & ID Number **Newton Rest Haven**

0024984

Report Period Beginning: **7/1/2005**

Ending: **6/30/2006**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karen Kinder	Administrator	100	\$ 149,046	Workers' Compensation Insurance	\$ 44,043	IDPH License Fee	\$	
				Unemployment Compensation Insurance		Advertising: Employee Recruitment		
				FICA Taxes	111,087	Health Care Worker Background Check		
				Employee Health Insurance	61,755	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	5,572	
				Background checks	1,352	Licenses & Fees	519	
				Employee Benefits	43,270	IL Public Aid	50,370	
				Employee Physicals	900			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	()	
			\$ 149,046			Non-allowable advertising	()	
B. Administrative - Other						Yellow page advertising	()	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 56,461	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Blue & Co	Accounting		\$ 20,122			\$	Out-of-State Travel	\$
Oldfield Law Group	Legal Fees		870				In-State Travel	8,185
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							Entertainment Expense	()
			\$ 20,992				(agree to Sch. V, line 24, col. 8)	
				TOTAL		\$	TOTAL	\$ 11,640

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$5520
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (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? _____
- (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. \$ 2,208 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,370
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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 benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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.