

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029397

Facility Name: New Way

Address: 80 Knupp School Lane Anna 62906
 Number City Zip Code

County: Union

Telephone Number: (618) 833-2299 **Fax #** (618) 833-4993

HFS ID Number: 371173155001

Date of Initial License for Current Owners: 3/11/1986

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Richard Stroh **Telephone Number:** (618) 833-5070x11

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Richard Stroh</u>	
	(Title) <u>Asst. Comptroller</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number New Way

0029397 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 5840

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	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			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>5,564</u>			<u>5,564</u>
14	TOTALS	<u>5,564</u>			<u>5,564</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.27%

D. How many bed-hold days during this year were paid by the Department?

104 (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 01/16/2003

J. Was the facility purchased or leased after January 1, 1978?

YES Date 01/16/2003 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number New Way# 0029397

Report Period Beginning:

01/01/06

Ending:

12/31/06**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs 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	
	A. General Services											
1	Dietary	17,975	1,696	1,794	21,465		21,465		21,465			1
2	Food Purchase		39,679		39,679		39,679		39,679			2
3	Housekeeping		3,380	944	4,324		4,324	66	4,390			3
4	Laundry											4
5	Heat and Other Utilities			11,812	11,812		11,812	242	12,054			5
6	Maintenance		3,602	1,515	5,117		5,117	5,231	10,348			6
7	Other (specify):*											7
8	TOTAL General Services	17,975	48,357	16,065	82,397		82,397	5,539	87,936			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	173,996	6,085	12,964	193,045		193,045	932	193,977			10
10a	Therapy		275	7,440	7,715		7,715		7,715			10a
11	Activities			563	563		563		563			11
12	Social Services		1,318	1,087	2,405		2,405	(1,081)	1,324			12
13	CNA Training	1,702		245	1,947		1,947		1,947			13
14	Program Transportation		3,227	3,240	6,467		6,467	361	6,828			14
15	Other (specify):* Day Training			130,372	130,372		130,372	(130,372)				15
16	TOTAL Health Care and Programs	175,698	10,905	155,911	342,514		342,514	(130,160)	212,354			16
	C. General Administration											
17	Administrative	39,945		4,000	43,945		43,945	4,553	48,498			17
18	Directors Fees							524	524			18
19	Professional Services			29,487	29,487		29,487	(28,019)	1,468			19
20	Dues, Fees, Subscriptions & Promotions			1,795	1,795		1,795	(232)	1,563			20
21	Clerical & General Office Expenses		1,595	2,403	3,998		3,998	6,474	10,472			21
22	Employee Benefits & Payroll Taxes			37,622	37,622		37,622	4,116	41,738			22
23	Inservice Training & Education			24	24		24		24			23
24	Travel and Seminar							93	93			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			2,775	2,775		2,775	157	2,932			26
27	Other (specify):*											27
28	TOTAL General Administration	39,945	1,595	78,106	119,646		119,646	(12,334)	107,312			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	233,618	60,857	250,082	544,557		544,557	(136,955)	407,602			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 New Way #0029397 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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
	D. Ownership										
30	Depreciation			15,226	15,226		15,226	872	16,098		30
31	Amortization of Pre-Op. & Org.			512	512		512		512		31
32	Interest			10,664	10,664		10,664	(10,664)			32
33	Real Estate Taxes			4,847	4,847		4,847	110	4,957		33
34	Rent-Facility & Grounds							475	475		34
35	Rent-Equipment & Vehicles							205	205		35
36	Other (specify):* See Page 25			45,713	45,713		45,713	(45,713)			36
37	TOTAL Ownership			76,962	76,962		76,962	(54,715)	22,247		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			24,047	24,047		24,047		24,047		42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			24,047	24,047		24,047		24,047		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	233,618	60,857	351,091	645,566		645,566	(191,670)	453,896		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 New Way

0029397

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ (130,372)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	560	30		9
10	Interest and Other Investment Income	(1,259)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(9,405)	32		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	(160)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,102)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,578)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(41,135)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(1,183)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (191,634)		\$	30

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)	(36)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (36)		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (191,670)		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					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

New Way

ID# 0029397

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	PAC Dues	\$ (77)	20	1
2	Chamber Dues	(25)	20	2
3	Clothing	(1,081)	12	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				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	(1,183)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number New Way

0029397

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	66	0	0	0	0	0	0	0	0	0	66	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	242	0	0	0	0	0	0	0	0	0	242	5
6	Maintenance	0	318	4,913	0	0	0	0	0	0	0	0	5,231	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	626	4,913	0	0	0	0	0	0	0	0	5,539	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	932	0	0	0	0	0	0	0	0	932	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	(1,081)	0	0	0	0	0	0	0	0	0	0	(1,081)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	361	0	0	0	0	0	0	0	0	0	361	14
15	Other (specify):*	(130,372)	0	0	0	0	0	0	0	0	0	0	(130,372)	15
16	TOTAL Health Care and Programs	(131,453)	361	932	0	0	0	0	0	0	0	0	(130,160)	16
	C. General Administration													
17	Administrative	0	0	4,553	0	0	0	0	0	0	0	0	4,553	17
18	Directors Fees	0	524	0	0	0	0	0	0	0	0	0	524	18
19	Professional Services	(4,102)	83	(24,000)	0	0	0	0	0	0	0	0	(28,019)	19
20	Fees, Subscriptions & Promotions	(262)	30	0	0	0	0	0	0	0	0	0	(232)	20
21	Clerical & General Office Expenses	0	1,123	5,351	0	0	0	0	0	0	0	0	6,474	21
22	Employee Benefits & Payroll Taxes	0	4,116	0	0	0	0	0	0	0	0	0	4,116	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	93	0	0	0	0	0	0	0	0	0	93	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	157	0	0	0	0	0	0	0	0	0	157	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(4,364)	6,126	(14,096)	0	0	0	0	0	0	0	0	(12,334)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(135,817)	7,113	(8,251)	0	0	0	0	0	0	0	0	(136,955)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number New Way

0029397

Report Period Beginning:

01/01/06 Ending:

12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	560	312	0	0	0	0	0	0	0	0	0	872	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,664)	0	0	0	0	0	0	0	0	0	0	(10,664)	32
33	Real Estate Taxes	0	110	0	0	0	0	0	0	0	0	0	110	33
34	Rent-Facility & Grounds	0	0	475	0	0	0	0	0	0	0	0	475	34
35	Rent-Equipment & Vehicles	0	0	205	0	0	0	0	0	0	0	0	205	35
36	Other (specify):*	(45,713)	0	0	0	0	0	0	0	0	0	0	(45,713)	36
37	TOTAL Ownership	(55,817)	422	680	0	(54,715)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(191,634)	7,535	(7,571)	0	(191,670)	45							

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
Don J. Pippins	98	Liberty House	Marion	ILS 1-3	Anna	CILA
Victor Metzger	2	Holly Hill	Anna	ILS 4	Metropolis	CILA
		Lincoln Square	Jonesboro	JR's Centre	Anna	Workshop
		Pilot House	Cairo	kel-Tech Management	Anna	Mgmt Co.
		Krypton	Mertopolis			
		Glen Brook	Vienna			
		Mulberry Manor	Anna			

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	3 Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 66	\$ 66 1
2	V	5 Utilities		kel-Tech Management Co.	25.00%	242	242 2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	318	318 3
4	V	14 Transportation		kel-Tech Management Co.	25.00%	361	361 4
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	524	524 5
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	83	83 6
7	V	20 Dues, Fees, Subscription		kel-Tech Management Co.	25.00%	30	30 7
8	V	21 Clerical & General Office		kel-Tech Management Co.	25.00%	1,123	1,123 8
9	V	22 Employee Benefits & Taxes		kel-Tech Management Co.	25.00%	4,116	4,116 9
10	V	24 Inservice Training		kel-Tech Management Co.	25.00%	93	93 10
11	V	26 Insurance		kel-Tech Management Co.	25.00%	157	157 11
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	110	110 12
13	V	30 Depreciation		kel-Tech Management Co.	25.00%	312	312 13
14	Total		\$			\$ 7,535	\$ * 7,535 14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)	
15	V	34	Rent	\$	kel-Tech Management Co.	25.00%	\$ 475	\$ 475	15
16	V	35	Equipment Rental		kel-Tech Management Co.	25.00%	205	205	16
17	V	10	Nursing		kel-Tech Management Co.	25.00%	932	932	17
18	V	17	Administration		kel-Tech Management Co.	25.00%	4,553	4,553	18
19	V	21	Clerical		kel-Tech Management Co.	25.00%	5,351	5,351	19
20	V	6	Maintenance		kel-Tech Management Co.	25.00%	4,913	4,913	20
21	V								21
22	V	19	Professional Services	24,000	kel-Tech Management Co.	25.00%		(24,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 24,000			\$ 16,429	\$ * (7,571)	39

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

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Don J. Pippins	Administrator	Administrator	98.00	67,042	8	20.00	ADM	\$ 39,945	17-1	1
2	Victor Metzger	RSD	RSD	2.00		40	100.00	RSD	55,583	10-1	2
3	Charlotte Metzger		Program Staff			14	35.00	Program Staff	3,902	10-2	3
4											4
5											5
6											6
7	kel-Tech Mgmt Co. Allocation										7
8	Diana Alley							Nursing	932		8
9	Jacob Alley							Maintenance	3,496		9
10	James A. Keller							Adminisrtation	4,553		10
11											11
12											12
13								TOTAL	\$ 108,411		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 New Way

0029397

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 kel-Tech Mgmt Co
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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	3	HOUSEKEEPING	Mgmt Fee Contribution	363,999	12	\$ 1,008	\$ 24,000	\$ 66	1
2	5	UTILITIES ELECT/GAS-B	Mgmt Fee Contribution	363,999	12	3,312	24,000	218	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	363,999	12	369	24,000	24	3
4	6	GROUNDS MAINT-B	Mgmt Fee Contribution	363,999	12	498	24,000	33	4
5	6	MAINTENANCE SUPPLIES-B	Mgmt Fee Contribution	363,999	12	748	24,000	49	5
6	6	MAINTENANCE VEHICLE	Mgmt Fee Contribution	363,999	12	292	24,000	19	6
7	6	PREVENTATIVE MAINT-B	Mgmt Fee Contribution	363,999	12	1,474	24,000	97	7
8	6	REPAIRS BLDG-B	Mgmt Fee Contribution	363,999	12	284	24,000	19	8
9	6	REPAIRS FURN/EQUIP-B	Mgmt Fee Contribution	363,999	12	1,536	24,000	101	9
10	14	REPAIRS VEHICLES-B	Mgmt Fee Contribution	363,999	12	721	24,000	48	10
11	14	TRANSPORTATION-B	Mgmt Fee Contribution	363,999	12	4,754	24,000	313	11
12	18	DIRECTOR'S FEES	Mgmt Fee Contribution	363,999	12	7,950	24,000	524	12
13	19	CONTRACT SERVICES	Mgmt Fee Contribution	363,999	12	455	24,000	30	13
14	19	LEGAL & ACCOUNTING-B	Mgmt Fee Contribution	363,999	12	810	24,000	53	14
15	20	DUES FEES SUBSCRIPTIONS-B	Mgmt Fee Contribution	363,999	12	452	24,000	30	15
16	21	EDUCATIONAL SUPPLIES-B	Mgmt Fee Contribution	363,999	12	144	24,000	10	16
17	21	BANK CHARGES-B	Mgmt Fee Contribution	363,999	12	0	24,000	0	17
18	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contribution	363,999	12	122	24,000	8	18
19	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	363,999	12	191	24,000	13	19
20	21	G & A MISC-B	Mgmt Fee Contribution	363,999	12	288	24,000	19	20
21	21	G & A MISC-B:88210 · SUPPLIE	Mgmt Fee Contribution	363,999	12	158	24,000	10	21
22	21	G & A SUPPLIES-B	Mgmt Fee Contribution	363,999	12	7,730	24,000	510	22
23	21	POSTAGE-B	Mgmt Fee Contribution	363,999	12	3,086	24,000	203	23
24	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	363,999	12	891	24,000	59	24
25	TOTALS					\$ 37,273	\$	\$ 2,456	25

Facility Name & ID Number New Way

0029397

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 kel-Tech Mgmt Co
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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	21	TELEPHONE-B	Mgmt Fee Contribution	363,999	12	\$ 2,367	\$ 24,000	\$ 156	1	
2	21	CELL PHONE EXPENSE	Mgmt Fee Contribution	363,999	12	1,641	24,000	108	2	
3	21	UTILITIES-INTERNET	Mgmt Fee Contribution	363,999	12	408	24,000	27	3	
4	22	INS EMP GROUP-B	Mgmt Fee Contribution	363,999	12	40,061	24,000	2,641	4	
5	22	INSURANCE W/C-B	Mgmt Fee Contribution	363,999	12	2,664	24,000	176	5	
6	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	363,999	12	19,708	24,000	1,299	6	
7	24	ADM. STAFF TRAINING	Mgmt Fee Contribution	363,999	12	1,406	24,000	93	7	
8	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	363,999	12	1,145	24,000	75	8	
9	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	363,999	12	1,246	24,000	82	9	
10	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	363,999	12	1,661	24,000	110	10	
11	30	DEPRECIATION	Mgmt Fee Contribution	363,999	12	4,731	24,000	312	11	
12	34	LEASE BLDG-B	Mgmt Fee Contribution	363,999	12	7,200	24,000	475	12	
13	35	LEASE EQUIP-B	Mgmt Fee Contribution	363,999	12	3,110	24,000	205	13	
14	10	Nursing	Mgmt Fee Contribution	363,999	12	14,140	14,140	24,000	932	14
15	17	Administration	Mgmt Fee Contribution	363,999	12	69,058	69,058	24,000	4,553	15
16	21	Clerical	Mgmt Fee Contribution	363,999	12	81,149	81,149	24,000	5,351	16
17	6	Maintenance	Mgmt Fee Contribution	363,999	12	74,519	74,519	24,000	4,913	17
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 326,215	\$ 238,866	\$ 21,508	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	Banterra Bank		X	Equipment Purchase	\$360.89	1/16/03	\$ 28,162	\$ 12,479	12/2009	6.0000	\$ 1,259	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$360.89		\$ 28,162	\$ 12,479			\$ 1,259	9								
B. Non-Facility Related*																				
10	Mary Hardesty		X	Stock Repurchase	\$284.00	1/2003	57,917	44,773	12/2017	5.0000	3,120	10								
11	Pat Lewis		X	Stock Repurchase	\$962.00	1/2003	109,833	90,178	12/2017	5.0000	6,285	11								
12												12								
13												13								
14	TOTAL Non-Facility Related				\$1,246.00		\$ 167,750	\$ 134,951			\$ 9,405	14								
15	TOTALS (line 9+line14)						\$ 195,912	\$ 147,430			\$ 10,664	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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

1. Real Estate Tax accrual used on 2005 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<u>5,300</u>	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.)			\$	<u>5,047</u>	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	<u>(253)</u>	3														
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<u>5,100</u>	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.			\$	<u>4,847</u>	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:																			
2001	<u>4,710</u>	8	<table border="1"> <thead> <tr> <th colspan="2">FOR BHF USE ONLY</th> </tr> </thead> <tbody> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2005 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </tbody> </table>			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
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																	
2002	<u>4,725</u>	9																	
2003	<u>4,785</u>	10																	
2004	<u>5,163</u>	11																	
2005	<u>5,047</u>	12																	
Sch. IX, Line 7	<u>4847</u>																		
kel-Tech Mgmt. Co. Alloc.	<u>110</u>																		
Sch. V, Line 33, Col. 8	<u>4957</u>																		

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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME New Way COUNTY Union

FACILITY IDPH LICENSE NUMBER 0029397

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

TELEPHONE (618) 833-5070 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

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>08-29-04-014</u>	<u>S29 T12 R1W PT SE SW</u>	\$ <u>5,046.76</u>	\$ <u>5,046.76</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>5,046.76</u>	\$ <u>5,046.76</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 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.

Facility Name & ID Number New Way

0029397 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,556 B. General Construction Type: Exterior Alum. Siding & Brick Frame Wood Number of Stories 2

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, 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: 2,588 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 512 4. Dates Incurred: 1/1/03

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	<u>Healthcare</u>	<u>43,560</u>	<u>1984</u>	<u>\$ 10,000</u>	1
2					2
3	TOTALS	43,560		\$ 10,000	3

Facility Name & ID Number New Way

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1985	\$ 298,575	\$ 8,610	40	\$ 8,610	\$	\$ 172,922	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Siding & Gutters		2003	8,200	442	15	547	105	4,225	9
10		Painting		2003	3,558	192	15	356	164	1,834	10
11		Carpet		2003	4,259		7	608	608	4,259	11
12		Bathroom Flooring/Fixture		2004	1,364		7	195	195	1,364	12
13		Flooring		2004	2,274		7	325	325	2,274	13
14		Flooring		2004	1,699		7	243	243	1,699	14
15		Blinds		2004	1,568		7	224	224	1,568	15
16		Water Softner		2005	1,344		7	192	192	1,344	16
17		Security Alarm		2005	875	241	7	125	(116)	248	17
18		Bedroom Addition		2003	2,145	116	15	143	27	1,106	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number New Way

0029397

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$ 325,861	\$ 9,601		\$ 11,568	\$ 1,967	\$ 192,843	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	6,258	3,850	566	(3,284)	7	3,850	72
73	Fully Depreciated Assets	30,749		3,652	3,652	7	30,749	73
74								74
75	TOTALS	\$ 37,007	\$ 3,850	\$ 4,218	\$ 368		\$ 34,599	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	Healthcare	1997 Ford Van	1996	\$ 20,929	\$	\$	\$	5	\$ 20,929	76
77	Healthcare	1999 Mercury Mountianeer	1999	21,567	1,775		(1,775)	5	19,633	77
78										78
79										79
80	TOTALS			\$ 42,496	\$ 1,775	\$	\$ (1,775)		\$ 40,562	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)		\$ 415,364	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 15,226	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 15,786	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 560	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 268,004	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?

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.	_____ /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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		294		294
4	Clinical Wages (b)		575		575
5	In-House Trainer Wages (c)		833		833
6	Transportation				
7	Contractual Payments		245		245
8	CNA Competency Tests				
9	TOTALS	\$	\$ 1,947	\$	\$ 1,947
10	SUM OF line 9, col. 1 and 2 (e)	\$	1,947		

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

Facility Name & ID Number New Way# 0029397

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	\$		\$	14

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

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,926	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	160,852		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	173,645		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 339,423	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000		13
14	Buildings, at Historical Cost	298,575		14
15	Leasehold Improvements, at Historical Cost	27,286		15
16	Equipment, at Historical Cost	79,503		16
17	Accumulated Depreciation (book methods)	(268,003)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	2,558		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,047)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DSP Training Receivable	1,523		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 149,395	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 488,818	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 6,162	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,775		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,741		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,100		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
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 22,778	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	192,430		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 192,430	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 215,208	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 273,610	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 488,818	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 203,606	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 203,606	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	70,004	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)	\$ 70,004	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)	\$ 273,610	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number New Way

0029397

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 594,691	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 594,691	3
B. Ancillary Revenue			
4	Day Care	118,060	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 118,060	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,524	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,524	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,295	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,295	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 715,570	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	82,397	31
32	Health Care	342,514	32
33	General Administration	119,646	33
B. Capital Expense			
34	Ownership	76,962	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	24,047	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 645,566	40
41	Income before Income Taxes (line 30 minus line 40)**	70,004	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 70,004	43

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

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

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

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

Facility Name & ID Number New Way

0029397

Report Period Beginning:

01/01/06

Ending:

12/31/06

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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,076	2,100	17,975	8.56	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	416	416	39,945	96.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,038	2,078	55,583	26.75	29
30	Habilitation Aides (DD Homes)	14,012	14,657	120,115	8.20	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,542	19,251	\$ 233,618 *	\$ 12.14	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	40	\$ 1,793	1-3	35
36	Medical Director	26	1,950	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	333	12,000	10-3	38
39	Pharmacist Consultant	18	900	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	35	2,085	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	31	1,088	12-3	45
46	Other(specify) <u>See Pg 25</u>	125	7,405		46
47					47
48					48
49	TOTAL (lines 35 - 48)	608	\$ 27,221		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 New Way

0029397

Report Period Beginning: 01/01/06

Ending: 12/31/06

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				
Don J.Pippins	Administrator	98	\$ 39,945	Workers' Compensation Insurance	\$ 4,961	IDPH License Fee	\$				
				Unemployment Compensation Insurance	6,300	Advertising: Employee Recruitment					
				FICA Taxes	17,467	Health Care Worker Background Check					
				Employee Health Insurance	8,744	(Indicate # of checks performed <u>6</u>)	96				
				Employee Meals		Patient Background Checks <u>15</u>	240				
				Illinois Municipal Retirement Fund (IMRF)*		See Pg 25	1,197				
				Employee Physicals	150						
				kel-Tech Mgmt Co Alloc	4,116	kel-Tech Mgmt Co Alloc	30				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 39,945	TOTAL (agree to Schedule V, line 22, col.8)			\$ 41,738	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 1,563	
(List each licensed administrator separately.)								Less: Public Relations Expense		()	
								Non-allowable advertising		()	
								Yellow page advertising		()	
B. Administrative - Other											
Description			Amount								
Connie Dodson			\$ 4,000								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 4,000								
(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			
Barnett & Livine	CPA Services		\$ 1,385			\$	Out-of-State Travel	\$			
FMGR	Legal Services		4,102								
kel-Tech Mgmt Alloc			24,000				In-State Travel				
TOTAL (agree to Schedule V, line 19, column 3)			\$ 29,487	TOTAL			\$	Seminar Expense			
(If total legal fees exceed \$5,000, attach copy of invoices.)								kel-Tech Mgmt Co Alloc	93		
								Entertainment Expense	()		
								(agree to Sch. V, line 24, col. 8)			
								TOTAL	\$ 93		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number New Way

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. IL Healthcare Assoc. \$883
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 917 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. _____
- (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. \$ 24,047
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? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ None 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? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- 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? No If no, please explain. Not required of this facility
- (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.

Related Parties Schedule VII
 Owners Compensation
 Jan 1, 2006 - Dec 31, 2006

	Totals / Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 110,449	23,871		3,462					43,171		39,945
Denise Pippins	\$ 70,869	26,149	7,500	25,050	12,170						
Diana Alley	\$ 111,497	12,015	36,000	9,600	15,647		24,095	14,140			
Jo Ann Keller	\$ 145,069			18,500	102,575	23,994					
James K. Keller	\$ 32,543			18,000	14,543						
Jacob Alley	\$ 53,045							53,045			
Jake Alley	\$ 37,527		37,527								
James A. Keller	\$ 100,019		20,150					69,058		10,811	
	\$ 661,018	\$ 62,035	\$ 101,178	\$ 74,612	\$ 144,935	\$ 23,994	\$ 24,095	\$ 136,243	\$ 43,171	\$ 10,811	\$ 39,945

New Way, Inc.
 Sch XVIII, Section B., Line 46
 Additional Detail of Consultants
 2006

	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
Admin. Consultant	\$ 80	\$ 4,000	17-3
Dental Consultant	24	1,200	10a-3
Psychiatric Consultant	9	675	10a-3
Psychologist Consultant	12	1,530	10a-3
	<u>\$ 125</u>	<u>\$ 7,405</u>	

New Way, Inc.
 Sch. XIX, Section F.
 Detail Analysis
 2006

Surety Bond	\$ 250
Subscriptions	29
IHCA Dues	883
IHCA PAC Dues	77
Chamber Dues	25
Sam's Club Membership	35
Contribution	160
Less:	
PAC Dues	(77)
Contributions	(160)
Chamber Dues	(25)
	<u>\$ 1,197</u>

New Way, Inc.
 Reconciliation of Sch. V, Line 30, Col. 8 to Sch. XI, Line 83, Col. 2
 2006

Sch. XI, Line 83, Col. 2	\$ 15,786
kel-Tech Mgmt Co. Allocation	312
Sch. V, Line 30, Col. 8	<u>\$ 16,098</u>

New Way, Inc.
 Reconciliation of Book To Taxable Income
 2006

Adjusted Book Income	\$ 70,005
Adjustment for accrual changes 2006	(80,869)
Add Provision for federal income tax	<u>31,190</u>
Taxable income per federal tax return	<u>\$ 20,326</u>

New Way, Inc.
 Analysis of Sch. V, Line 36, Col. 4
 2006

Bad Debt	\$ 4,578
State Income Tax	9,945
Federal Income Tax	<u>31,190</u>
Total	<u>\$ 45,713</u>