		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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

I. IDPH License ID Number: 0029397

Facility Name: New Way

Address: 80 Knupp School lane (Number) Anna (City) 62906 (Zip Code)

County: Union

Telephone Number: 618-833-2299 **Fax #** 618-833-7571

HFS ID Number: 371173155001

Date of Initial License for Current Owners: 03/11/2003

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/08 to 12/31/08 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) ____
	(Title) ____
Paid Preparer	(Signed) ____ (Date)
	(Print Name and Title) ____
	(Firm Name & Address) ____
	(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Don Pippins Telephone Number: 618-833-2299
Email Address:

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: 01/01/08 Ending: 12/31/08

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	5,561			5,561	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,561			5,561	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.96%

D. How many bed-hold days during this year were paid by the Department? _____ (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 01/16/2003

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

YES [X] Date 01/16/2003 NO [ ]

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	34,169	1,802	4,279	40,250		40,250	(1,190)	39,060			1
2	Food Purchase		39,552		39,552		39,552	66	39,618			2
3	Housekeeping	11,217	3,271	2,684	17,172		17,172		17,172			3
4	Laundry		660	167	827		827		827			4
5	Heat and Other Utilities			16,471	16,471		16,471	236	16,707			5
6	Maintenance	20,769	1,909	4,274	26,952		26,952	4,311	31,263			6
7	Other (specify):*											7
8	TOTAL General Services	66,155	47,194	27,875	141,224		141,224	3,423	144,647			8
	B. Health Care and Programs											
9	Medical Director			1,650	1,650		1,650		1,650			9
10	Nursing and Medical Records	154,003	4,804	14,300	173,107		173,107	894	174,001			10
10a	Therapy		1,941	6,140	8,081		8,081		8,081			10a
11	Activities											11
12	Social Services											12
13	CNA Training	764		735	1,499		1,499		1,499			13
14	Program Transportation							463	463			14
15	Other (specify):* DT Reimb.			191,446	191,446		191,446	(191,446)				15
16	TOTAL Health Care and Programs	154,767	6,745	214,271	375,783		375,783	(190,089)	185,694			16
	C. General Administration											
17	Administrative	21,154			21,154		21,154	4,329	25,483			17
18	Directors Fees							416	416			18
19	Professional Services			25,303	25,303		25,303	(23,951)	1,352			19
20	Dues, Fees, Subscriptions & Promotions			1,515	1,515		1,515	16	1,531			20
21	Clerical & General Office Expenses		2,402	190	2,592		2,592	7,847	10,439			21
22	Employee Benefits & Payroll Taxes			40,249	40,249		40,249	3,555	43,804			22
23	Inservice Training & Education			191	191		191		191			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			4,297	4,297		4,297	203	4,500			26
27	Other (specify):*											27
28	TOTAL General Administration	21,154	2,402	71,745	95,301		95,301	(7,585)	87,716			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	242,076	56,341	313,891	612,308		612,308	(194,251)	418,057			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: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			26,212	26,212		26,212	(4,996)	21,216			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,457	9,457		9,457	(10,243)	(786)			32
33	Real Estate Taxes			5,594	5,594		5,594	(45)	5,549			33
34	Rent-Facility & Grounds							431	431			34
35	Rent-Equipment & Vehicles							165	165			35
36	Other (specify):* State & Fed Taxes			18,975	18,975		18,975	(18,975)				36
37	TOTAL Ownership			60,238	60,238		60,238	(33,663)	26,575			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,814	3,814		3,814		3,814			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,326	33,326		33,326		33,326			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			37,140	37,140		37,140		37,140			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	242,076	56,341	411,269	709,686		709,686	(227,914)	481,772			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: 01/01/08 Ending: 12/31/08

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$ (191,446)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(55)	1		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	(5,666)	30		9
10	Interest and Other Investment Income	(786)	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	(9,457)	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	(190)	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	(2,700)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(16,275)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Income	(1,135)	1		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (227,710)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(42)		34
35	Other- Attach Schedule RE Tax	(162)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (204)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (227,914)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

New Way

ID# 0029397

Report Period Beginning: 01/01/08

Ending: 12/31/08

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (1,135)	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				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	(1,135)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,190)	0	0	0	0	0	0	0	0	0	0	(1,190)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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**	(1,190)	0	0	0	0	0	0	0	0	0	0	(1,190)	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):*	(191,446)	0	0	0	0	0	0	0	0	0	0	(191,446)	15
16	**TOTAL Health Care and Programs**	(191,446)	0	0	0	0	0	0	0	0	0	0	(191,446)	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	(42)	0	0	0	0	0	0	0	0	0	(42)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(190)	0	0	0	0	0	0	0	0	0	0	(190)	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**	(190)	(42)	0	0	0	0	0	0	0	0	0	(232)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(192,826)	(42)	0	0	0	0	0	0	0	0	0	(192,868)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(5,666)	0	0	0	0	0	0	0	0	0	0	(5,666)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,243)	0	0	0	0	0	0	0	0	0	0	(10,243)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(18,975)	0	0	0	0	0	0	0	0	0	0	(18,975)	36
37	**TOTAL Ownership**	(34,884)	0	0	0	0	0	0	0	0	0	0	(34,884)	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)**	(227,710)	(42)	0	0	0	0	0	0	0	0	0	(227,752)	45

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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			
Victor Metzger	2	Holly Hill	Anna			
		ILS	Anna			CILA
		JR Center	Anna			Workshop
		kel-Tech	Anna			Management Co.

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	$ 24,000	kel-Tech Management	25.00%	$ 23,958	$ (42)	1
2	V								2
3	V		see attached allocation						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			$ 24,000			$ 23,958	$ * (42)	14

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

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Don J. Pippins	Administrator	Adm./Maint.	98.00	38,400	12	20.00	Adm	$ 41,538	6-17	1
2	Lindsey Radcliffe	Adm. Assistant	QMRP (training)		385	4	10.00	Program	385	17	2
3											3
4											4
5											5
6	Don Pippins										6
7	Liberty House				6,000						7
8	Holly Hill				32,400						8
9											9
10	Lindsey Pippins										10
11	Holly Hill				385						11
12											12
13								TOTAL	$ 41,923		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: 01/01/08 Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: kel-Tech Manangement Co.
Street Address: 158 East Vienna St.
City / State / Zip Code: Anna, IL 62906
Phone Number: (618-833-5070
Fax Number: (618-833-4993

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Mgmt Fees	400,583	10	$ 1,100	$	24,000	$ 66	1
2	5	Utilities	Mgmt Fees	400,583	10	3,938		24,000	236	2
3	6	Maintenance	Mgmt Fees	400,583	10	3,684		24,000	221	3
4	14	Transportation	Mgmt Fees	400,583	10	7,729		24,000	463	4
5	18	Director's Fees	Mgmt Fees	400,583	10	6,950		24,000	416	5
6	19	Professional Services	Mgmt Fees	400,583	10	825		24,000	49	6
7	20	Dues, Fees, Subscriptions	Mgmt Fees	400,583	10	272		24,000	16	7
8	21	Clerical & General Office	Mgmt Fees	400,583	10	15,587		24,000	934	8
9	22	Employee Benefits	Mgmt Fees	400,583	10	59,344		24,000	3,555	9
10	26	Insurance	Mgmt Fees	400,583	10	3,383		24,000	203	10
11	30	Depreciation	Mgmt Fees	400,583	10	11,179		24,000	670	11
12	33	Real Estate Taxes	Mgmt Fees	400,583	10	1,945		24,000	117	12
13	34	Rent	Mgmt Fees	400,583	10	7,200		24,000	431	13
14	35	Equip Rental	Mgmt Fees	400,583	10	2,757		24,000	165	14
15	10	Nursing Wages	Mgmt Fees	400,583	10	14,916	14,916	24,000	894	15
16	17	Adm. Wages	Mgmt Fees	400,583	10	72,251	72,251	24,000	4,329	16
17	21	Clerical wages	Mgmt Fees	400,583	10	118,556	118,556	24,000	7,103	17
18	6	Maintenance Wages	Mgmt Fees	400,583	10	68,271	68,271	24,000	4,090	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 399,887	$ 273,994		$ 23,958	25

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	$381.00	01/16/03	$ 28,162	$ 4,035	14/14/09	6.0000	$ 752	1
2												2
3												3
4												4
5	Ford Credit		X	Vehicle Purchase	$253.00	05/22/08	10,668	9,279	05/22/12	6.4900	381	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$634.00		$ 38,830	$ 13,314			$ 1,133	9
	B. Non-Facility Related*											
10	Wm. & Pat Lewis		X	Stock Purchase	$1,973.00	01/16/03	235,250	167,771	12/05/17	6.7500	11,803	10
11	Pat Lewis		X	Stock Purchase	$921.00	01/16/03	129,938	78,331	01/03/18	6.7500	5,513	11
12	Mary Hardesty		X	Stock Purchase	$457.00	01/16/03	57,917	23,944	12/31/13	6.7500	2,737	12
13												13
14	TOTAL Non-Facility Related				$3,351.00		$ 423,105	$ 270,046			$ 20,053	14
15	TOTALS (line 9+line14)						$ 461,935	$ 283,360			$ 21,186	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ 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.)

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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 2007 report.	$ 5,750	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.)	$ 5,588	2
3. Under or (over) accrual (line 2 minus line 1).	$ (162)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 5,756	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.	$ 5,594	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2003	4,785	8
	2004	5,163	9
	2005	5,047	10
	2006	5,425	11
	2007	5,588	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME New Way COUNTY Union

FACILITY IDPH LICENSE NUMBER 0029397

CONTACT PERSON REGARDING THIS REPORT Don Pippins

TELEPHONE 618-697-1122 FAX #: 618-549-1990

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

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-29-04-014	S29 T12 R1W PT SE SW	$ 5,588.00	$ 5,588.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 5,588.00	$ 5,588.00

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 direct 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 hom (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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2008

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: 01/01/08 Ending: 12/31/08

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

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

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

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

1. Total Amount Incurred: 3,100
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 1
4. Dates Incurred: 01/01/03

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	Healthcare	43,560	2003	$ 10,000	1
2					2
3	TOTALS	43,560		$ 10,000	3

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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		2003	1985	$ 298,575	$ 8,610	40	$ 8,610	$	$ 190,142	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Siding & Gutters			2003	8,200	358	15	547	189	3,145	9
10	Painting			2003	3,558	155	15	356	201	2,077	10
11	Carpet			2003	4,259		7	608	608	3,446	11
12	Bathroom Flooring			2004	1,364		7	195	195	959	12
13	Flooring			2004	2,274		7	325	325	1,544	13
14	Flooring			2004	1,699		7	243	243	1,073	14
15	Blinds			2004	1,568		7	224	224	952	15
16	Water Softeners			2005	1,344		7	192	192	648	16
17	Security Alarm			2005	875	123	7	125	2	382	17
18	Pavillion			2007	4,700	1,151	7	671	(480)	1,510	18
19	Fencing			2007	2,204	540	7	315	(225)	551	19
20	Decking			2007	1,709	419	7	244	(175)	427	20
21	Wood Flooring			2007	5,958	1,459	7	851	(608)	1,064	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: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Bedroom Addition	2003	$ 2,145	$ 94	15	$ 143	$ 49	$ 810	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)		$ 340,432	$ 12,909		$ 13,649	$ 740	$ 208,730	70

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

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	$ 40,454	$ 491	$ 5,098	$ 4,607	7-Jan	$ 25,899	71
72	Current Year Purchases	3,252	3,252	232	(3,020)	7	232	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 43,706	$ 3,743	$ 5,330	$ 1,587		$ 26,131	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	$ 21,567	$ 159	$	$ (159)	5	$ 21,567	76
77	Healthcare	2008 Ford Focus	2008	15,668	9,401	1,567	(7,834)	5	1,567	77
78										78
79										79
80	TOTALS			$ 37,235	$ 9,560	$ 1,567	$ (7,993)		$ 23,134	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)	$ 431,373	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 26,212	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,546	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,666)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 257,995	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2009	$
13.	/2010	$
14.	/2011	$

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

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

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

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

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

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	90

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		235		235
4	Clinical Wages (b)		529		529
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		735		735
8	CNA Competency Tests				
9	TOTALS	$	$ 1,499	$	$ 1,499
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,499			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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 prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									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: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (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	$ 146,289	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	80,048		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)	275,525		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 501,862	$	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	41,858		15
16	Equipment, at Historical Cost	80,941		16
17	Accumulated Depreciation (book methods)	(290,124)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 141,250	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 643,112	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 12,565	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,480		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,224		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,756		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(10,900)		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 14,125	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	131,232		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)**	$ 131,232	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 145,356	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 497,756	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 643,112	$	48

*(See instructions.)

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 395,049	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 395,049	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	102,705	7	2
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)**	$ 102,705	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)**	$ 497,754	24	*

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

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 608,669	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 608,669	3
	B. Ancillary Revenue		
4	Day Care	191,446	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 191,446	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	9,989	11
12	Gift and Coffee Shop	1,502	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)**	$ 11,491	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	786	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 786	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)**	$ 812,392	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	141,224	31
32	Health Care	375,783	32
33	General Administration	95,301	33
	B. Capital Expense		
34	Ownership	60,238	34
	C. Ancillary Expense		
35	Special Cost Centers	3,814	35
36	Provider Participation Fee	33,326	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 709,686	40
41	**Income before Income Taxes (line 30 minus line 40)****	102,706	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 102,706	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.

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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	2,164	2,284	20,223	8.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	1,553	1,625	13,946	8.58	15
16	Dishwashers					16
17	Maintenance Workers	1,000	1,000	20,769	20.77	17
18	Housekeepers	1,250	1,270	11,217	8.83	18
19	Laundry					19
20	Administrator	400	400	20,769	51.92	20
21	Assistant Administrator	24	24	385	16.04	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	2,080	2,120	57,046	26.91	29
30	Habilitation Aides (DD Homes)	12,117	12,417	96,957	7.81	30
31	Medical Records					31
32	Other Health Care(specify)			764		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	20,588	21,140	$ 242,076 *	$ 11.45	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	48	$ 1,713	1-3	35
36	Medical Director	24	1,650	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	250	12,000	10-3	38
39	Pharmacist Consultant	24	1,100	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	24	825	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	24	580	10a-3	45
46	Other(specify)				46
47	Psychiatrist	24	2,550	10a-3	47
48	Psychologist	24	2,185	10a-3	48
49	TOTAL (lines 35 - 48)	442	$ 22,603		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Don Pippins	Adm	98	$ 20,769
Lindsey Radcliffe	Asst Adm		385
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 21,154

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
kel-Tech management Co.	Mgmt Co.	$ 24,000
Barnett & Levine	CPA	1,070
FMGR	Legal	233
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 25,303

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,647
Unemployment Compensation Insurance	6,266
FICA Taxes	14,925
Employee Health Insurance	8,920
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Medicare	3,491
Mgmt Co. Allocation	3,555
TOTAL (agree to Schedule V, line 22, col.8)	$ 43,804

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	105
Health Care Worker Background Check	70
(Indicate # of checks performed ____)	
Patient Background Checks	
Association Dues	1,090
Surety Bond	250
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,515

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number New Way # 0029397 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **New Way** **#** **0029397** **Report Period Beginning:** **01/01/08** **Ending:** **12/31/08**

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 $960**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(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? _____
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. $ _____ Line _____

(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. $ **33,326**
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? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **55** 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? **Yes**
g. Does the facility transport residents to and from day training? _____
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? _____
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? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

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