

Facility Name & ID Number WAY-FAIR

0040238 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	97	Skilled (SNF)	97	34,405	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	34,405	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	10,486	1,124		11,610	8	
9	SNF/PED					9	
10	ICF	13,280	4,566		17,846	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	23,766	5,690		29,456	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.62%

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)

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

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 08/02/1968

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ 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 WPS Medicare

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

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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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	249,529	38,100	291,224	578,853		578,853	578,853			1
2	Food Purchase										2
3	Housekeeping	84,986	20,608	7,294	112,888		112,888	112,888			3
4	Laundry	34,132	1,245	58,950	94,327		94,327	94,327			4
5	Heat and Other Utilities			133,385	133,385		133,385	133,385			5
6	Maintenance	26,357	17,101	20,270	63,728		63,728	63,728			6
7	Other (specify):*										7
8	TOTAL General Services	395,004	77,054	511,123	983,181		983,181	983,181			8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,403,728	58,296	56,702	1,518,726		1,518,726	1,518,726			10
10a	Therapy										10a
11	Activities	263,929	2,194	1,742	267,865		267,865	267,865			11
12	Social Services	36,854	36	1,638	38,528		38,528	38,528			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,704,511	60,526	60,082	1,825,119		1,825,119	1,825,119			16
	C. General Administration										
17	Administrative	34,952	84	14,657	49,693		49,693	49,693			17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes			464,620	464,620		464,620	464,620			22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			65,281	65,281		65,281	65,281			26
27	Other (specify):*										27
28	TOTAL General Administration	34,952	84	544,558	579,594		579,594	579,594			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,134,467	137,664	1,115,763	3,387,894		3,387,894	3,387,894			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			94,651	94,651		94,651		94,651			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			94,651	94,651		94,651		94,651			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,947	385,642	440,589		440,589		440,589			39
40	Barber and Beauty Shops	12,191	1,074	618	13,883		13,883		13,883			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	12,191	56,021	386,260	454,472		454,472		454,472			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,146,658	193,685	1,596,674	3,937,017		3,937,017		3,937,017			45

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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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	0	49

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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

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

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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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

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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		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						\$				\$								
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

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.)

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

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. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	BLDG & PROP	16,000	1968	\$ 3,573	1
2					2
3	TOTALS	16,000		\$ 3,573	3

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XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	72		1968		\$ 447,106	\$ 2,790	40	\$ 11,178	\$ 8,388	\$ 447,106	4
5	25		1972		234,761	5,854	40	5,854		215,118	5
6											6
7											7
8											8
	Improvement Type**										
9		BLDG SERVICES EQ	1968		243,076					243,076	9
10		LAND IMP	1969		37,468					37,468	10
11		FIXED EQ	1969		5,832					5,832	11
12		BLDG SERVICE EQ	1972		201,101					201,101	12
13		FIXED EQ	1983		825					825	13
14		ROOF	1984		40,600					40,600	14
15		LAND IMP	1984		12,950					12,950	15
16		PATIO	1986		3,841		20			3,841	16
17		ROOF	1986		45,335		20			45,335	17
18		REMODELING	1986		8,437		20			8,437	18
19		BLDG SERVICES EQ	1986		3,098		10			3,098	19
20		BLDG SERVICES EQ	1988		24,373		20			24,373	20
21		BLDG SERVICES EQ	1988		10,060		10			10,060	21
22		BLDG	1990		3,336	28	20	28		3,336	22
23		BLDG SERVICES EQ	1990		3,997		10			3,997	23
24		REMODELING	1991		3,347		10			3,347	24
25		BLDG SERVICES EQ	1992		7,630		15			7,630	25
26		BLDG SERVICES EQ	1992		18,326	916	20	916		16,643	26
27		BLDG	1992		825		5			825	27
28		BLDG SERVICES EQ	1992		1,070		5			1,070	28
29		RENOVATIONS	1993		14,369		15			14,369	29
30		BLDG	1994		11,829		5			11,829	30
31		BLDG SERVICES EQ	1994		25,100	278	15	1,673	1,395	25,100	31
32		BLDG SERVICES EQ	1995		42,394	2,826	15	2,826		41,696	32
33		BLDG SERVICES EQ-CHILLER REPAIR	1996		2,850	190	15	190		2,581	33
34		BLDG SERVICES EQ-DINING ROOM	1996		6,024		5			6,024	34
35		FIXED EQ-82 GALLON WATER HEATER	1996		3,645		5			3,645	35
36		FIXED EQ-25 DOOR LOCKS	1996		1,044		5			1,044	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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LAND IMP CHAIN LINK FENCE	1996	\$ 854	\$ 57	15	\$ 57	\$	\$ 741	37
38	BLDG SVCE EQ SEWER LINE	1997	8,796	440	20	440		5,353	38
39	BLDG ROOF REPAIR	1997	45,608		10			45,608	39
40	BLDG 20 SINKS	1997	3,814	191	20	191		2,370	40
41	BLDG 18 FAN CONTROLS	1997	2,322		10			2,322	41
42	FIXED EQ 140 DOOR GUARDS	1997	3,993		5			3,993	42
43	FIXED EQ 30 SMOKE DETECTORS	1997	2,300		10			2,300	43
44	FIXED EQ 12 TOILET RISERS	1998	1,320		10			1,320	44
45	BLDG DINING ROOM GLASS	1998	1,439	72	20	72		840	45
46	BLDG ROOF REPAIR	1998	1,170		5			1,170	46
47	BLDG SVCE EQ 30 HP FAN MOTOR	1998	1,347		5			1,347	47
48	BLDG SVCE EQ FIRE ALARM REPAIR	1998	1,112		3			1,112	48
49	BLDG SVCE EQ CHILLER REPAIR	1998	13,126	1,009	15	1,009		11,789	49
50	BLDG SVCE EQ 100 GAL WATER HEATER	1998	2,628		10			2,628	50
51	BLDG SVCE EQ WATER SOFTENER	1998	1,400		10			1,400	51
52	BLDG SVCE EQ NURSE CALL SYSTEM	1998	10,386		10			10,386	52
53	BLDG SVCE EQ 7.5 HP MOTOR CHILLER	1998	998		5			998	53
54	BLDG SVCE EQ CIRCULATION PUMP	1998	1,485		5			1,485	54
55	BLDG SVCE EQ CHILLER COMPRESSOR	1999	12,785	852	15	852		9,160	55
56	BLDG SVCE EQ FAN SPEED CONTROLS	1999	1,097	110	10	110		1,097	56
57	BLDG WANDERGUARD MONITOR	2000	1,040		5			1,040	57
58	BLDG DINING ROOM WINDOW	2000	704	35	20	35		324	58
59	BLDG WALLPAPER	2000	800		5			800	59
60	BLDG NURSE CALL ADDITION	2000	1,425	143	10	143		1,335	60
61	BLDG SVCE EQ CHILLER REPAIR	2000	1,461		5			1,461	61
62	BLDG SVCE EQ 14 FAUCETS	2000	1,884	94	20	94		854	62
63	BLDG SVCE ADDTL NURSE CALLS	2000	953	95	10	95		855	63
64	BLDG 3X8 DOOR	2001	3,869	193	20	193		1,705	64
65	BLDG CARPET	2001	4,474		5			4,474	65
66	BLDG SVCE EQ AIR CURTAINS	2001	1,663	111	15	111		990	66
67	BLDG SVCE EQ HOT WATER HEATER	2001	1,948	195	10	195		1,592	67
68	BLDG SVCE EQ FIRE ALARM	2001	2,317		5			2,317	68
69	LAND IMPRV PARKING LOT	2001	614	41	15	41		331	69
70	TOTAL (lines 4 thru 69)		\$ 1,605,781	\$ 16,520		\$ 26,303	\$ 9,783	\$ 1,567,853	70

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

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,605,781	\$ 16,520		\$ 26,303	\$ 9,783	\$ 1,567,853	1
2	BLDG ROOF REPAIR	2002	4,805		5			4,805	2
3	BLDG WALL COVERING	2002	904		5			904	3
4	BLDG WALLBOARD	2002	3,803	300	10	300		2,186	4
5	BLDG 4 TRUSSES	2002	1,560	68	20	68		487	5
6	BLDG SVCE EQ FIRE ALARM	2002	17,474	1,747	10	1,747		13,103	6
7	BLDG SVCE EQ 3 PHASE IN SINK	2002	1,418	142	10	142		994	7
8	BLDG SVCE EQ HVAC COIL	2002	725	48	15	48		380	8
9	BLDG SVCE EQ KEYLESS ENTRY	2002	4,995	500	10	500		3,916	9
10	BLDG WALLGUARD COVERING	2003	806	40	20	40		277	10
11	BLDG ROOF REPLACEMENT	2003	84,670	9,467	10	9,467		63,012	11
12	BLDG CEILING TILE,FLOOR TILE,WALLPAPER, LABOR	2003	121,122	5,606	20	5,606		36,566	12
13	BLDG NURSES STATION	2003	6,486	324	20	324		2,106	13
14	BLDG SVCE EQ CHAIR REPAIR	2003	11,810		5			11,810	14
15	HOSP IMPROVEMENT SIDEWALK	2003	2,400	160	15	160		1,080	15
16	BLDG VALANCE SUNROOM	2004	751	75	10	75		444	16
17	BLDG NURSES STATION	2004	21,210	1,061	20	1,061		6,277	17
18	BLDG CEILING TILE,FLOOR TILE,WALLPAPER, LABOR	2004	27,575	1,379	20	1,379		7,885	18
19	BLDG STAINLESS STEEL COUNTER SHUTTER	2004	2,527	126	20	126		704	19
20	BLDG ARCHITECTURE DESIGN - NURSES STATION	2004	4,516	113	40	113		603	20
21	BLDG MUD JACKING - PATIO	2004	1,845	123	15	123		625	21
22	BLDG - MUD JACKING - PATIO	2005	3,690	246	15	246		1,230	22
23	BLDG - CARPET - ENTRANCE	2005	1,335	267	5	267		1,335	23
24	BLDG - ROOF REPLACEMENT	2005	78,950	7,895	10	7,895		35,528	24
25	BLDG - SPRINKLER ADDITION	2005	2,425	97	25	97		469	25
26	BLDG - WANDERGUARD ADDITION	2005	2,390	478	5	478		1,992	26
27	FIXED EQ - BATHTUB	2005	19,245	962	20	962		4,169	27
28	BLDG-ATRIUM ADDITION	2006	71,893	3,243	20	3,243		10,921	28
29	BLDG-SVCS EQ-CHILLER COMPRESSOR	2006	14,836	2,967	5	2,967		11,621	29
30	BLDG-SVCS EQ-PORTABLE A/C SYSTEM	2006	9,900	1,980	5	1,980		7,425	30
31	BLDG-SVCS EQ-NEW CHILLER	2006	57,380	5,738	10	5,738		21,039	31
32	BLDG-SVCS EQ-KITCHEN FREEZER	2006	13,972	931	15	931		3,492	32
33	LAND IMP-CONCRETE SIDEWALK	2006	9,188	613	15	613		2,400	33
34	TOTAL (lines 1 thru 33)		\$ 2,212,387	\$ 63,216		\$ 72,999	\$ 9,783	\$ 1,827,638	34

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

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	
1	Totals from Page 12B, Carried Forward		\$ 2,212,387	\$ 63,216		\$ 72,999	\$ 9,783	\$ 1,827,638	1
2	LAND IMP-HANDRAILS-OUTSIDE	2006	1,665	111	15	111		435	2
3	LAND IMP-CONCRETE PAD-CHILLER	2006	2,634	176	15	176		674	3
4	LAND IMP-CONCRETE PAD-CANOPY	2006	2,890	193	15	193		675	4
5	LAND IMP-SIGNAGE-OUTSIDE	2006	11,918	1,192	10	1,192		3,703	5
6	LAND IMP-CONCRETE COURTYARD	2007	3,250	217	15	217		434	6
7	BLDG-STEEL FIRE DOOR	2007	2,200	110	20	110		330	7
8	BLDG-FIRE DOOR FRAME	2007	3,046	152	20	152		406	8
9	BLDG-WANDERGUARD MONITORS	2009	4,995	833	5	999	166	833	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	TOTAL (lines 1 thru 33)		\$ 2,244,985	\$ 66,200		\$ 76,149	\$ 9,949	\$ 1,835,128	34

**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	\$ 286,194	\$ 14,888	\$ 14,888	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 286,194	\$ 14,888	\$ 14,888	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,534,752	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 81,088	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 91,037	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,949	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,835,128	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: _____

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: _____ *

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 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 type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	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 WAY-FAIR# 0040238Report Period Beginning: 07/01/2008Ending: 06/30/2009**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 06/30/2009

(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	\$ 2,393,773	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>3,312,042</u>)	4,814,006		3
4	Supply Inventory (priced at)	325,633		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	287,472		7
8	Accounts Receivable (owners or related parties)	352,707		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,173,591	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,660		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	24,330,031		16
17	Accumulated Depreciation (book methods)	(14,137,167)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	310,967		21
22	Other Long-Term Assets (spe <u>INVESTMENTS</u>)	297,283		22
23	Other(specify): <u>CASH</u>	36,992		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,845,766	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,019,357	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,283,137	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,780,702		29
30	Accrued Salaries Payable	316,487		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		481,184		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,861,510	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,664,221		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)	\$ 1,664,221	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,525,731	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 13,493,626	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,019,357	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 13,581,602	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 13,581,602	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(550,673)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	462,697	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)	\$ (87,976)	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)	\$ 13,493,626	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,379,937	1
2	Discounts and Allowances for all Levels	(1,788,772)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,591,165	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	9,429	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,429	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	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)	\$ 3,600,594	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,937,017	31
32	Health Care		32
33	General Administration		33
B. Capital Expense			
34	Ownership		34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,937,017	40
41	Income before Income Taxes (line 30 minus line 40)**	(336,423)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (336,423)	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.

Facility Name & ID Number **WAY-FAIR**

0040238

Report Period Beginning: **07/01/2008**

Ending:

06/30/2009

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	1,896	2,080	\$ 39,072	\$ 18.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,076	19,703	344,600	17.49	3
4	Licensed Practical Nurses	15,196	18,060	203,589	11.27	4
5	CNAs & Orderlies	59,125	64,787	720,889	11.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,946	5,215	217,541	41.71	8
9	Activity Director	1,936	2,080	24,046	11.56	9
10	Activity Assistants	2,477	2,750	20,362	7.40	10
11	Social Service Workers	2,009	2,131	36,854	17.29	11
12	Dietician	1,168	1,248	46,748	37.46	12
13	Food Service Supervisor	1,896	2,080	36,608	17.60	13
14	Head Cook	8,720	9,583	91,395	9.54	14
15	Cook Helpers/Assistants					15
16	Dishwashers	12,366	13,235	99,012	7.48	16
17	Maintenance Workers	1,962	2,111	26,357	12.49	17
18	Housekeepers	8,494	9,320	84,986	9.12	18
19	Laundry	3,746	4,125	34,132	8.27	19
20	Administrator	1,896	2,080	73,592	35.38	20
21	Assistant Administrator					21
22	Other Administrative	3,013	3,372	34,682	10.29	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					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTY SHOP	1,351	1,499	12,193	8.13	33
34	TOTAL (lines 1 - 33)	150,273	165,459	\$ 2,146,658 *	\$ 12.97	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$		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 WAY-FAIR

0040238

Report Period Beginning: 07/01/2008

Ending: 06/30/2009

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. IHA
- (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? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,046 Line 190
- (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? _____
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. \$ IN CA
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? _____ 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. \$ _____ 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? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NA
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
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? YES
Firm Name: MCDOWELL, KENSHALO & JESOP, CPA'S
- (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? NA
Attach invoices and a summary of services for all architect and appraisal fees.