

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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.

<p>I. IDPH License ID Number: <u>0045753</u></p> <p>Facility Name: <u>Litchfield Healthcare Center</u></p> <p>Address: <u>1285 East Union Avenue</u> <u>Litchfield</u> <u>62056</u> Number City Zip Code</p> <p>County: <u>Montgomery</u></p> <p>Telephone Number: <u>(217)324-3996</u> Fax # <u>(217)324-6032</u></p> <p>HFS ID Number: <u>382795206</u></p> <p>Date of Initial License for Current Owners: <u>02/19/1992</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Michael W Martin</u> Telephone Number: <u>(217) 789-7700</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2007</u> to <u>12/31/2007</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>15 Old State Capital Plaza, Ste 200 Springfield, IL 62701</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(217)789-7700</u> (217)753-1654</td> </tr> <tr> <td colspan="2"> 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 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen LLP</u> <u>15 Old State Capital Plaza, Ste 200 Springfield, IL 62701</u>		(Telephone) <u>(217)789-7700</u> (217)753-1654	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	
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center

0045753 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>26</u>	Skilled (SNF)	<u>26</u>	<u>9,490</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>97</u>	Intermediate (ICF)	<u>97</u>	<u>35,405</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>770</u>	<u>186</u>	<u>4,922</u>	<u>5,878</u>	8
9	SNF/PED					9
10	ICF	<u>19,339</u>	<u>4,634</u>	<u>137</u>	<u>24,110</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,109</u>	<u>4,820</u>	<u>5,059</u>	<u>29,988</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.80%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

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 Note: Non-allowable costs have been eliminated in Schedule V, Column 7.

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

I. On what date did you start providing long term care at this location?
 Date started 01/01/1992

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 01/01/1992 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 26 and days of care provided 4,920

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center # 0045753 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	165,113	12,988	6,203	184,304		184,304		184,304		1
2	Food Purchase		154,928		154,928		154,928	(506)	154,422		2
3	Housekeeping	114,163	25,859		140,022		140,022		140,022		3
4	Laundry	65,670	4,173		69,843		69,843		69,843		4
5	Heat and Other Utilities			135,881	135,881		135,881		135,881		5
6	Maintenance	54,075	9,625	47,530	111,230		111,230		111,230		6
7	Other (specify):*										7
8	TOTAL General Services	399,021	207,573	189,614	796,208		796,208	(506)	795,702		8
	B. Health Care and Programs										
9	Medical Director			27,000	27,000		27,000		27,000		9
10	Nursing and Medical Records	1,335,505	114,548	10,528	1,460,581		1,460,581		1,460,581		10
10a	Therapy	374,433	10,011	2,813	387,257		387,257		387,257		10a
11	Activities	55,173	4,835	1,339	61,347		61,347		61,347		11
12	Social Services	32,017		3,254	35,271		35,271		35,271		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,797,128	129,394	44,934	1,971,456		1,971,456		1,971,456		16
	C. General Administration										
17	Administrative	64,127		205,717	269,844		269,844		269,844		17
18	Directors Fees										18
19	Professional Services			57,479	57,479		57,479		57,479		19
20	Dues, Fees, Subscriptions & Promotions			8,249	8,249		8,249		8,249		20
21	Clerical & General Office Expenses	170,301	10,459	29,522	210,282		210,282		210,282		21
22	Employee Benefits & Payroll Taxes			396,364	396,364		396,364		396,364		22
23	Inservice Training & Education										23
24	Travel and Seminar			19,688	19,688		19,688	(19,688)			24
25	Other Admin. Staff Transportation			1,546	1,546		1,546		1,546		25
26	Insurance-Prop.Liab.Malpractice			134,051	134,051		134,051		134,051		26
27	Other (specify):*										27
28	TOTAL General Administration	234,428	10,459	852,616	1,097,503		1,097,503	(19,688)	1,077,815		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,430,577	347,426	1,087,164	3,865,167		3,865,167	(20,194)	3,844,973		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Litchfield Healthcare Center

#0045753

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			34,152	34,152		34,152	31,938	66,090			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			77,268	77,268		77,268		77,268			33
34	Rent-Facility & Grounds			151,611	151,611		151,611		151,611			34
35	Rent-Equipment & Vehicles			6,953	6,953		6,953		6,953			35
36	Other (specify):*											36
37	TOTAL Ownership			269,984	269,984		269,984	31,938	301,922			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,812	970	121,782		121,782		121,782			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,420	66,420		66,420		66,420			42
43	Other (specify):* Non-allowable Cos			132,137	132,137		132,137	(132,137)				43
44	TOTAL Special Cost Centers		120,812	199,527	320,339		320,339	(132,137)	188,202			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,430,577	468,238	1,556,675	4,455,490		4,455,490	(120,393)	4,335,097			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(506)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,618)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	31,938	30		9
10	Interest and Other Investment Income				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				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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(82,252)	43		24
25	Fund Raising, Advertising and Promotional	(2,775)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(56,180)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (120,393)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (120,393)		37

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

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

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		x	\$	38
39					39
40	Gift and Coffee Shops		x		40
41	Barber and Beauty Shops		x		41
42	Laboratory and Radiology		x		42
43	Prescription Drugs		x		43
44	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Litchfield Healthcare Center

ID# 0045753

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	NonAllowable marketing	\$ (11,395)	43	1
2	Disallow Lab expense	(14,830)	43	2
3	Disallow X-Ray expense	(9,980)	43	3
4	Disallow Travel and Seminar expense	(19,688)	24	4
5	Offset Misplaced items	(224)	43	5
6	Offset other expense	(63)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(56,180)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Litchfield Healthcare Center# 0045753

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(506)	0	0	0	0	0	0	0	0	0	0	(506)	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	(506)	0	(506)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	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	(19,688)	0	0	0	0	0	0	0	0	0	0	(19,688)	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	(19,688)	0	(19,688)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(20,194)	0	(20,194)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Litchfield Healthcare Center

0045753

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	SUMMARY TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	31,938	0	0	0	0	0	0	0	0	0	0	31,938	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	31,938	0	31,938	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):*	(132,137)	0	0	0	0	0	0	0	0	0	0	(132,137)	43
44	TOTAL Special Cost Centers	(132,137)	0	(132,137)	44									
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(120,393)	0	(120,393)	45									

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Family Senior Care	100	LaSalle Healthcare Center	LaSalle	Family Senior Care	Miami Beach, FL	Managed Care

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	N/A	\$			\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center # 0045753 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	N/A								\$	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center

0045753 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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	N/A								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

SEE ACCOUNTANTS' COMPILATION REPORT

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 2006 report.		\$	6,802	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.)	2006	\$	74,962	2
3. Under or (over) accrual (line 2 minus line 1).		\$	68,160	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	44,800	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.			(35,692)	
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.		\$	77,268	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	62,573	8	
	2003	65,253	9	
	2004	70,095	10	
	2005	72,691	11	
	2006	39,270	12	
Accrual is based on prior year expense.				
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Litchfield Healthcare Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0045753

CONTACT PERSON REGARDING THIS REPORT Theodore Duay

TELEPHONE (305) 892-1790 FAX #: (305) 538-2699

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-100-598-00</u>	<u>PT W 1/2 SW Lands Corp Limits</u>	\$ <u>71,383.06</u>	\$ <u>71,383.06</u>
2. <u>11-100-598-05</u>	<u>PT W 1/2 SW Lands Corp Limits</u>	\$ <u>3,578.72</u>	\$ <u>3,578.72</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>74,961.78</u>	\$ <u>74,961.78</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center

0045753

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,189 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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	<u>NA</u>			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Building Improvement		1982	2,131		20			2,131	9
10	Building Improvement		1983	2,986		20			2,986	10
11	Building Improvement		1984	53,393		20			53,393	11
12	Building Improvement		1985	55,378		20			55,378	12
13	Building Improvement		1986	2,920		20			2,920	13
14	Building Improvement		1989	5,059		20	253	253	4,510	14
15	Building Improvement		1990	3,677		20	184	184	3,138	15
16	Building Improvement		1991	3,100		20	155	155	2,624	16
17	Building Improvement		1992	10,816		20	541	541	8,441	17
18	Building Improvement		1993	14,559		20			14,559	18
19	Building Improvement		1994	94,548		20	4,727	4,727	40,002	19
20	Windows		1997	599		20	30	30	331	20
21	Rooftop A/C Unit		1996	8,850		20	443	443	4,928	21
22	Painting		1996	5,000		20	250	250	2,892	22
23	Air Conditioner		1997	3,416		20	171	171	1,791	23
24	Fire Alarm System		1997	732		20	37	37	378	24
25	Ground Sign		1997	2,900		20	145	145	1,555	25
26	Paving/Sidewalks Repair		1998	950		15	63	63	627	26
27	HVAC		1998	10,764		20	538	538	5,335	27
28	HVAC - Condensor Replacement Unit		1998	4,275		15	285	285	2,636	28
29	Carpet		1998	6,276		5			6,276	29
30	Landscaping		1998	6,222		20	311	311	4,942	30
31	Handicap Ramp		1998	950		20	48	48	465	31
32	Fire Alarm System		1999	6,809		10	681	681	6,129	32
33	Replace 2 AO Smith Water		1999	12,500		10	1,250	1,250	11,042	33
34	6: Islandaire A/C Heaters		1999	6,267		5			6,267	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

SEE ACCOUNTANTS' COMPILATION REPORT

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

STATE OF ILLINOIS

Facility Name & ID Number Litchfield Healthcare Center

0045753

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Condensor & Coil Repair W/N Freezer	2000	\$ 3,800	\$	15	\$ 253	\$ 253	\$ 2,088	37
38	Electric Transfer Switch Installed	2000	2,675		10	268	268	2,233	38
39	F/A Smoke Detection Inspect	2000	782		10	78	78	598	39
40	2: Islandaire Heat/Cool Units	2000	2,168		10	217	217	1,700	40
41	Architect Service F/A Systems	2000	16,988		10	1,699	1,699	12,742	41
42	10: 12 BTU HVAC Units	2000	11,038		10	1,104	1,104	6,562	42
43	Architect Fees, FA System	2000	8,612		15	574	574	5,453	43
44	Water Heater - Laundry	2000	5,400		10	540	540	3,870	44
45	Architect Retainage & Reimbursement	2000	5,238		10	524	524	3,755	45
46	Replace Fire Alarm System App. No. 1	2000	85,313		10	8,531	8,531	61,139	46
47	Replace Fire Alarm System App. No. 2	2000	45,074		10	4,507	4,507	32,300	47
48	Architect Fee, Reimburse, 11%	2001	3,379		10	338	338	2,394	48
49	Construction Fee, Fire Alarm, App #3 (2.5%)	2001	3,343		10	334	334	2,367	49
50	7: Islandaire HVAC Units	2001	7,140		15	476	476	3,150	50
51	Use Tax - 7 : Islandaire HVAC Units	2001	446		15	30	30	207	51
52	R Concrete, Employee Entrance	2001	1,520		15	101	101	666	52
53	R Concrete, Emergency Entrance	2001	1,635		15	109	109	718	53
54	Repairs Roof & Gutters, Pat Rm	2001	3,649		10	365	365	2,311	54
55	Nurse Call System Upgrade	2001	4,350		10	435	435	2,683	55
56									56
57	Service, Nurse Call System	2002	830		10	83	83	512	57
58	Domestic W/H Investigation	2002	2,100		10	210	210	1,330	58
59	Architect Fees - Blue Prints	2002	900		15	60	60	355	59
60	2: Fire Rated Exit Device	2002	6,753	675	10	675		3,769	60
61	Replace Doors & Frams	2002	16,358	1,091	15	1,091		6,090	61
62	Floor Prep Base Tile Work	2002	15,246	1,016	15	1,016		5,758	62
63	Plumbing / Kitchen	2002	5,627	281	20	281		1,593	63
64	Repairs Wall & Door - Kitchen	2002	9,664	644	15	644		3,650	64
65	Electrical Work - Kitchen	2002	1,063	53	20	53		301	65
66	Ext Reclamation / Concrete Patch	2002	2,194	146	15	146		828	66
67	Horns & Strobes Instl. - F/A System	2002	2,850	285	10	285		1,591	67
68	HVAC RTU - 2nd Floor Hall N Station	2002	6,695	446	15	446		2,417	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 607,907	\$ 4,637		\$ 35,585	\$ 30,948	\$ 420,806	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Litchfield Healthcare Center

0045753

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 607,907	\$ 4,637		\$ 35,585	\$ 30,948	\$ 420,806	1
2	HVAC RTU 1st Floor TV Room	2002	7,102	473	15	473		2,563	2
3	Architect Fees / Convert Beds	2002	6,230	415	15	415		2,248	3
4	Architect Fees Pat Rm Wardrobes	2002	387	26	15		(26)	387	4
5									5
6	WanderGuard System Install	2003	688	69	10	69		333	6
7	Repairs WanderGuard Sys	2003	934	93	10	93		458	7
8	2: Door Closer - WanderGuard	2003	1,067	107	10	107		508	8
9	Auto Fire Protection	2003	2,600	260	10	260		1,213	9
10	WanderGuard System Install	2003	6,651	665	10	665		3,159	10
11	WanderGuard System Install	2003	30,049	3,005	10	3,005		14,524	11
12	Replace 848: ceiling tiles	2003	5,168	345	15	345		1,581	12
13	Architect & Engineering Fee Wardr	2003	444	30	15	30		140	13
14	Use Tax Architect & Engineering Fee Wardr	2003	30	2	15	2		9	14
15	Replace HVSRTU #4	2003	7,528	502	15	502		2,259	15
16	Ceiling Mounted Exhaust Fan	2003	5,817	582	10	582		2,619	16
17	2 Ton Condensing Unit Air Hand	2003	8,047	536	15	536		2,412	17
18	2: 5 Ton A/R Unit Kitchen	2003	16,728	1,673	10	1,673		7,528	18
19	Lumber - Gazebo	2003	791	79	10	79		336	19
20	Rocks, 8 Ton Dirt - Gazebo	2003	123	12	10	12		51	20
21									21
22	Double Roof Instl - Gazebo	2004	3,122	312	10	312		1,274	22
23	6: Heat/Cool Units - Res Rms	2004	5,687	1,137	5	1,137		4,454	23
24	Use Tax - 6: Heat/Cool Units - Res	2004	384	77	5	77		301	24
25	Water Cooler, Surface Mount	2004	509	51	10	51		187	25
26	Use Tax - Water Cooler, Surface Mount	2004	29	3	10	3		11	26
27	Water Softner System	2004	3,163	316	10	316		1,027	27
28	Repair Nurse Call	2004	1,105	111	10	111		351	28
29	2: Heat/Cool Units	2004	1,940	194	10	194		679	29
30	Use Tax - 2: Heat/Cool Units	2004	131	13	10	13		46	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 724,361	\$ 15,725		\$ 46,647	\$ 30,922	\$ 471,464	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	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 12B, Carried Forward		\$ 724,361	\$ 15,725		\$ 46,647	\$ 30,922	\$ 471,464	1
2	Maglock - Wanderguard	2005	738	74	10	74		148	2
3	Fire System - Hood/Kitchen	2005	68	7	10	7		13	3
4	Fire Suppression Hood	2005	2,065	207	10	207		413	4
5									5
6	Window - Add'l Ramp	2005	2,113	141	15	141		351	6
7	Exterior concrete work- sidewalks and curbing	2005	34,881	2,325	15	2,325		5,817	7
8	Window - Front Lobby	2005	3,879	259	15	259		646	8
9	Major Landscaping Improvements	2005	3,322	738	5	738		1,734	9
10									10
11	HVAC	2006	3,320		15	221	221	332	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)		\$ 774,747	\$ 19,476		\$ 50,619	\$ 31,143	\$ 480,918	34

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 204,662	\$ 13,544	\$ 13,951	\$ 407	3-15	\$ 153,290	71
72	Current Year Purchases	11,322	1,132	1,520	388	5	1,520	72
73	Fully Depreciated Assets	349,248					349,248	73
74								74
75	TOTALS	\$ 565,232	\$ 14,676	\$ 15,471	\$ 795		\$ 504,058	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	NA			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,339,979	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 34,152	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,090	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,938	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 984,976	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	NA				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nationwide Health Properties - (Merger to) Omega Healthcare Partners L.P. as of Sept 27,1991

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: <u>1974</u>	<u>123</u>	<u>07/01/1989</u>	\$ <u>151,611</u>	<u>10</u>	<u>40</u>	3
4	Additions						4
5							5
6							6
7	TOTAL	123		\$ 151,611			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 N/A
N/A

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

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: \$ 6,953 Description: Air Mattress \$813, Dishwasher \$846, Copier \$4448, Postage Meter \$846

(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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning 01/01/1989

Ending 06/01/08

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

Fiscal Year Ending Annual Rent

12. 12/31/2008 \$ 62,500

13. /2009 \$

14. /2010 \$

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	10A (1,3)	6712 hrs	\$ 193,006		\$	\$ 1,769	6,712	\$ 194,775	1
2	Licensed Speech and Language Development Therapist	10A(1,3)	1876 hrs	53,969			1,287	1,876	55,256	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	4433 hrs	127,458	41	2,813	6,955	4,474	137,226	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts	0			112,113		112,113	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Oxygen & Ambulance</u>	39(2)		0			8,699		8,699	13
14	TOTAL			\$ 374,433	41	\$ 2,813	\$ 130,823	13,062	\$ 508,069	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center

0045753

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,174,041	\$ 5,174,041	1
2	Cash-Patient Deposits	268	268	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,063)	540,913	540,913	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	83,217	83,217	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to/from Leasehold	498	498	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,798,937	\$ 5,798,937	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	232,066	774,747	15
16	Equipment, at Historical Cost	108,469	565,232	16
17	Accumulated Depreciation (book methods)	(150,226)	(984,976)	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)	\$ 190,309	\$ 355,003	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,989,246	\$ 6,153,940	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 479,686	\$ 479,686	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	2,453,708	2,453,708	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,800	44,800	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	817,940	817,940	36
37	Due to/from Related Facilities	2,788,700	2,788,700	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,584,834	\$ 6,584,834	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Worker's Comp Revolver - L/T	179,463	179,463	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 179,463	\$ 179,463	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,764,297	\$ 6,764,297	46
47	TOTAL EQUITY(page 18, line 24)	\$ (775,051)	\$ (610,357)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,989,246	\$ 6,153,940	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XV. BALANCE SHEET

Line 36: Other Current Liabilities (specify):

	<u>Operating</u>	<u>After Consolidation</u>
Garnishments	(532)	(532)
Miscellaneous Deductions	1,350	1,350
Accrued Unemployment	30,485	30,485
Accrued Employer Insurance	2,559	2,559
Accrued Self Funded Insurance	143,173	143,173
Accrued Insurance	250,065	250,065
Accrued 401(k) Company Matcl	1,653	1,653
Accrued Workers Compensatio	138,962	138,962
Accrued Provider Assessment	(923)	(923)
SAVA Accruals	70,277	70,277
Accrued Management Fees	180,871	180,871
	<u>817,940</u>	<u>817,940</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (429,420)	1
2	Restatements (describe):		2
3			3
4	Prior Period Adjustment	(5,587)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (435,007)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(340,044)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (340,044)	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)	\$ (775,051)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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		Amount	
Revenue			
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,385,420	1
2	Discounts and Allowances for all Levels	(255,997)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,129,423	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	772,924	6
7	Oxygen	19,157	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 792,081	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	506	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	171,384	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,115	19
20	Radiology and X-Ray	6,012	20
21	Other Medical Services	5,324	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 193,341	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	600	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 600	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,115,446	30

2		Amount	
Expenses			
A. Operating Expenses			
31	General Services	796,208	31
32	Health Care	1,971,456	32
33	General Administration	1,097,503	33
B. Capital Expense			
34	Ownership	269,984	34
C. Ancillary Expense			
35	Special Cost Centers	253,919	35
36	Provider Participation Fee	66,420	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,455,490	40
41	Income before Income Taxes (line 30 minus line 40)**	(340,044)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (340,044)	43

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

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

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

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

Facility Name & ID Number Litchfield Healthcare Center

0045753

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

12/31/2007

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	1,376	1,520	\$ 50,976	\$ 33.54	1
2	Assistant Director of Nursing	5,879	6,312	112,308	17.79	2
3	Registered Nurses	4,540	4,495	110,327	24.54	3
4	Licensed Practical Nurses	19,970	19,085	309,063	16.19	4
5	CNAs & Orderlies	66,095	73,629	745,706	10.13	5
6	CNA Trainees					6
7	Licensed Therapist	11,786	13,021	374,433	28.76	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,901	6,564	55,173	8.41	10
11	Social Service Workers	2,048	2,160	32,017	14.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,080	19,672	165,113	8.39	15
16	Dishwashers					16
17	Maintenance Workers	3,818	4,161	54,075	13.00	17
18	Housekeepers	12,159	13,266	114,163	8.61	18
19	Laundry	7,635	8,391	65,670	7.83	19
20	Administrator	2,136	2,240	64,127	28.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,180	16,370	170,301	10.40	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	510	590	7,125	12.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,113	191,476	\$ 2,430,577 *	\$ 12.69	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	Monthly	\$ 6,203	1(3)	35
36	Medical Director	Monthly	27,000	9(3)	36
37	Medical Records Consultant	10	540	10(3)	37
38	Nurse Consultant	Monthly	5,362	10(3)	38
39	Pharmacist Consultant	Monthly	4,626	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,339	11(3)	44
45	Social Service Consultant	56	3,254	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	89	\$ 48,324		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Litchfield Healthcare Center
Provider # 0045753
12/31/2007
XIX: Support Schedules

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount
Allison Lori Stone LLC	Legal	1,000
George Orblish	Legal	695
Moore Stphens Lovelace	Accounting	1,800
RSM McGladrey	Accounting	11,551
National Datacare Corp	Accounting	334
Hamlin & Burton	Legal	1,000
Press Ganey Assoc	Legal/Corporate Compliance	245
LTCI	Legal/Corporate Compliance	561
Payday USA	Payroll Processing	6,159
ABIS DATAVOICE	Computer Maint	415
IT Management	Computer Maint	29,400
IVANS	Data Processing	4,277
Consolidated Comm	Internet Services	42
Total (Agreee to Sch V Line 29, Col 3)		57,479

See Accountants' Compilation Report

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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center# 0045753Report Period Beginning: 01/01/2007Ending: 12/31/2007**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? No
If YES, give association name and amount. N/A
- (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? N/A
- (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? N/A
- (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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,140 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,420
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 506
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees