



Facility Name & ID Number Litchfield Healthcare Center

# 0045753 Report Period Beginning: 1/1/09 Ending: 12/31/09

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>194</u>	<u>234</u>	<u>4,821</u>	<u>5,249</u>	8
9	SNF/PED					9
10	ICF	<u>17,807</u>	<u>7,101</u>	<u>303</u>	<u>25,211</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,001</u>	<u>7,335</u>	<u>5,124</u>	<u>30,460</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.85%

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 1/1/92

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

YES  Date 1/1/92 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 4,732

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Litchfield Healthcare Center

# 0045753

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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
	<b>A. General Services</b>										
1	Dietary	189,581	15,634	5,700	210,915		210,915	210,915			1
2	Food Purchase		164,336		164,336		164,336	164,336			2
3	Housekeeping	134,807	11,581		146,388		146,388	146,388			3
4	Laundry	58,511	20,689		79,200		79,200	79,200			4
5	Heat and Other Utilities			154,475	154,475		154,475	154,475			5
6	Maintenance	55,953	21,339	91,485	168,777		168,777	8,085	176,862		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	438,852	233,579	251,660	924,091		924,091	8,085	932,176		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000	24,000			9
10	Nursing and Medical Records	1,626,988	81,340	7,942	1,716,270		1,716,270	1,716,270			10
10a	Therapy	427,599	4,623		432,222		432,222	432,222			10a
11	Activities	63,960	4,817	2,488	71,265		71,265	71,265			11
12	Social Services	33,137		2,488	35,625		35,625	35,625			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,151,684	90,780	36,918	2,279,382		2,279,382		2,279,382		16
	<b>C. General Administration</b>										
17	Administrative	72,106		232,827	304,933		304,933	304,933			17
18	Directors Fees										18
19	Professional Services			102,910	102,910		102,910	102,910			19
20	Dues, Fees, Subscriptions & Promotions			4,091	4,091		4,091	4,091			20
21	Clerical & General Office Expenses	124,221	4,060	43,697	171,978		171,978	171,978			21
22	Employee Benefits & Payroll Taxes			523,184	523,184		523,184	523,184			22
23	Inservice Training & Education										23
24	Travel and Seminar			40,934	40,934		40,934	(40,934)			24
25	Other Admin. Staff Transportation			8,238	8,238		8,238	8,238			25
26	Insurance-Prop.Liab.Malpractice			11,217	11,217		11,217	11,217			26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	196,327	4,060	967,098	1,167,485		1,167,485	(40,934)	1,126,551		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,786,863	328,419	1,255,676	4,370,958		4,370,958	(32,849)	4,338,109		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:

1/1/09

Ending:

12/31/09

## 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	
	<b>D. Ownership</b>											
30	Depreciation			34,152	34,152	34,152	54,822	88,974				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			152,044	152,044	152,044		152,044				34
35	Rent-Equipment & Vehicles			11,744	11,744	11,744		11,744				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			275,208	275,208	275,208	54,822	330,030				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		130,499	20,895	151,394	151,394		151,394				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):* <b>Non-allowable cost</b>	32,705		181,734	214,439	214,439	(214,439)					43
44	<b>TOTAL Special Cost Centers</b>	32,705	130,499	269,049	432,253	432,253	(214,439)	217,814				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,819,568	458,918	1,799,933	5,078,419	5,078,419	(192,466)	4,885,953				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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(12,112)	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	54,822	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	(6,377)	43		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	(93,131)	43		24
25	Fund Raising, Advertising and Promotional	(3,474)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(132,194)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (192,466)		\$	30

<b>BHF USE ONLY</b>					
48		49	50	51	52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (192,466)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Litchfield Healthcare Center

ID# 0045753

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (15,432)	43	1
2	Disallow Lab expense	(40,584)	43	2
3	Disallow X-Ray expense	(6,871)	43	3
4	Disallow Radiology expense	(4,099)	43	4
5	Disallos Misc Receipts	836	43	5
6	Disallos Misc Receipts & Other expense	(490)	43	6
7	Disallow Travel & Seminar expense	(40,934)	24	7
8	Disallow Marketing salaries	(32,705)	43	8
9	Reclass Assets to Repairs per regulations	8,085	6	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	<b>Total</b>		(132,194)	49

SEE ACCOUNTANTS' COMPILATION REPORT

**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
Mariner Health Care	100	LaSalle Health Care Center	LaSalle	N/A		

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			N/A				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	<b>Total</b>		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization N/A  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	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									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**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax

1. Real Estate Tax accrual used on 2008 report.		\$	<b>7,618</b>	<b>1</b>
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.)	<b>2008</b>	\$	<b>81,607</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>73,989</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>3,192</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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.			<b>Unreconciled Difference</b>	<b>87</b>
<b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>77,268</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	<b>2004</b>	<b>70,095</b>	<b>8</b>	
	<b>2005</b>	<b>72,691</b>	<b>9</b>	
	<b>2006</b>	<b>74,962</b>	<b>10</b>	
	<b>2007</b>	<b>78,758</b>	<b>11</b>	
	<b>2008</b>	<b>81,607</b>	<b>12</b>	
<b>Accrual is based on prior year expense.</b>				
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>81,606.88</u>	\$ <u>81,606.88</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

**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

**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).

N/A

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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:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>N/A</u>			\$	1
2					2
3	<b>TOTALS</b>			\$	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
	<b>Improvement Type**</b>									
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	5,016	14
15	Building Improvement	1990		3,677		20	184	184	3,506	15
16	Building Improvement	1991		3,100		20	155	155	2,934	16
17	Building Improvement	1992		10,816		20	541	541	9,523	17
18	Building Improvement	1993		14,559		20			14,559	18
19	Building Improvement	1994		94,548		20	4,727	4,727	49,456	19
20	Windows	1997		599		20	30	30	391	20
21	Rooftop A/C Unit	1996		8,850		20	443	443	5,814	21
22	Painting	1996		5,000		20	250	250	3,392	22
23	Air Conditioner	1997		3,416		20	171	171	2,133	23
24	Fire Alarm System	1997		732		20	37	37	452	24
25	Ground Sign	1997		2,900		20	145	145	1,845	25
26	Paving/Sidewalks Repair	1998		950		15	63	63	753	26
27	HVAC	1998		10,764		20	538	538	6,411	27
28	HVAC - Condensor Replacement Unit	1998		4,275		15	285	285	3,206	28
29	Carpet	1998		6,276		5			6,276	29
30	Landscaping	1998		6,222		20	311	311	5,564	30
31	Handicap Ramp	1998		950		20	48	48	561	31
32	Fire Alarm System	1999		6,809		10			6,809	32
33	Replace 2 AO Smith Water	1999		12,500		10	208	208	12,500	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

Facility Name &amp; ID Number Litchfield Healthcare Center

# 0045753

Report Period Beginning:

1/1/09

Ending:

12/31/09

## 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	Condensator & Coil Repair W/N Freezer	2000	\$ 3,800	\$	15	\$ 253	\$ 253	\$ 2,594	37
38	Electric Transfer Switch Installed	2000	2,675		10	174	174	2,675	38
39	F/A Smoke Detection Inspect	2000	782		10	78	78	754	39
40	2: Islandaire Heat/Cool Units	2000	2,168		10	217	217	2,134	40
41	Architect Service F/A Systems	2000	16,988		10	1,699	1,699	16,140	41
42	10: 12 BTU HVAC Units	2000	11,038		10	1,104	1,104	8,770	42
43	Architect Fees, FA System	2000	8,612		15	574	574	6,601	43
44	Water Heater - Laundry	2000	5,400		10	540	540	4,950	44
45	Architect Retainage & Reimbursement	2000	5,238		10	524	524	4,803	45
46	Replace Fire Alarm System App. No. 1	2000	85,313		10	8,531	8,531	78,201	46
47	Replace Fire Alarm System App. No. 2	2000	45,074		10	4,507	4,507	41,314	47
48	Architect Fee, Reimburse, 11%	2001	3,379		10	338	338	3,070	48
49	Construction Fee, Fire Alarm, App #3 (2.5%)	2001	3,343		10	334	334	3,035	49
50	7: Islandaire HVAC Units	2001	7,140		15	476	476	4,102	50
51	Use Tax - 7 : Islandaire HVAC Units	2001	446		15	30	30	267	51
52	R Concrete, Employee Entrance	2001	1,520		15	101	101	868	52
53	R Concrete, Emergency Entrance	2001	1,635		15	109	109	936	53
54	Repairs Roof & Gutters, Pat Rm	2001	3,649		10	365	365	3,041	54
55	Nurse Call System Upgrade	2001	4,350		10	435	435	3,553	55
56									56
57	Service, Nurse Call System	2002	830		10	83	83	678	57
58	Domestic W/H Investigation	2002	2,100		10	210	210	1,750	58
59	Architect Fees - Blue Prints	2002	900		15	60	60	475	59
60	2: Fire Rated Exit Device	2002	6,753		10	675	675	5,119	60
61	Replace Doors & Frams	2002	16,358		15	1,091	1,091	8,272	61
62	Floor Prep Base Tile Work	2002	15,246		15	1,016	1,016	7,790	62
63	Plumbing / Kitchen	2002	5,627		20	281	281	2,155	63
64	Repairs Wall & Door - Kitchen	2002	9,664		15	644	644	4,938	64
65	Electrical Work - Kitchen	2002	1,063		20	53	53	407	65
66	Ext Reclamation / Concrete Patch	2002	2,194		15	146	146	1,120	66
67	Horns & Strobes Instl. - F/A System	2002	2,850		10	285	285	2,161	67
68	HVAC RTU - 2nd Floor Hall N Station	2002	6,695		15	446	446	3,309	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 607,907	\$		\$ 33,768	\$ 33,768	\$ 490,158	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Litchfield Healthcare Center

# 0045753

Report Period Beginning:

1/1/09

Ending:

12/31/09

**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 607,907	\$		\$ 33,768	\$ 33,768	\$ 490,158	1
2	HVAC RTU 1st Floor TV Room	2002	7,102		15	473	473	3,509	2
3	Architect Fees / Convert Beds	2002	6,230		15	415	415	3,078	3
4	Architect Fees Pat Rm Wardrobes	2002	387		15			387	4
5									5
6	WanderGuard System Install	2003	688		10	69	69	471	6
7	Repairs WanderGuard Sys	2003	934		10	93	93	644	7
8	2: Door Closer - WanderGuard	2003	1,067		10	107	107	722	8
9	Auto Fire Protection	2003	2,600		10	260	260	1,733	9
10	WanderGuard System Install	2003	6,651		10	665	665	4,489	10
11	WanderGuard System Install	2003	30,049		10	3,005	3,005	20,534	11
12	Replace 848: ceiling tiles	2003	5,168		15	345	345	2,271	12
13	Architect & Engineering Fee Wardr	2003	444		15	30	30	200	13
14	Use Tax Architect & Engineering Fee Wardr	2003	30		15	2	2	13	14
15	Replace HVSRTU #4	2003	7,528		15	502	502	3,263	15
16	Ceiling Mounted Exhaust Fan	2003	5,817		10	582	582	3,783	16
17	2 Ton Condensing Unit Air Hand	2003	8,047		15	536	536	3,484	17
18	2: 5 Ton A/R Unit Kitchen	2003	16,728		10	1,673	1,673	10,874	18
19	Lumber - Gazebo	2003	791		10	79	79	494	19
20	Rocks, 8 Ton Dirt - Gazebo	2003	123		10	12	12	75	20
21									21
22	Double Roof Instl - Gazebo	2004	3,122		10	312	312	1,898	22
23	6: Heat/Cool Units - Res Rms	2004	5,687		5	96	96	5,687	23
24	Use Tax - 6: Heat/Cool Units - Res	2004	384		5	6	6	384	24
25	Water Cooler, Surface Mount	2004	509		10	51	51	289	25
26	Use Tax - Water Cooler, Surface Mount	2004	29		10	3	3	17	26
27	Water Softner System	2004	3,163		10	316	316	1,659	27
28	Repair Nurse Call	2004	1,105		10	111	111	573	28
29	2: Heat/Cool Units	2004	1,940		10	194	194	1,067	29
30	Use Tax - 2: Heat/Cool Units	2004	131		10	13	13	72	30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 724,361	\$		\$ 43,718	\$ 43,718	\$ 561,828	34

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

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	<b>Totals from Page 12B, Carried Forward</b>		\$ 724,361	\$		\$ 43,718	\$ 43,718	\$ 561,828	1
2	Maglock - Wanderguard	2005	738		10	74	74	296	2
3	Fire System - Hood/Kitchen	2005	68		10	7	7	27	3
4	Fire Suppression Hood	2005	2,065		10	207	207	827	4
5									5
6	Window - Add'l Ramp	2005	2,113		15	141	141	633	6
7	Exterior concrete work- sidewalks and curbing	2005	34,881		15	2,325	2,325	10,467	7
8	Window - Front Lobby	2005	3,879		15	259	259	1,164	8
9	Major Landscaping Improvements	2005	3,322		5	738	738	3,210	9
10									10
11	HVAC	2006	3,320		15	221	221	774	11
12									12
13	Telephone System	2008	9,450		20	473	473	709	13
14	Roof Repair	2008	95,233		20	4,762	4,762	7,143	14
15	Fire System	2008	4,950		20	247	247	371	15
16	Elevator Repairs	2008	16,881		20	844	844	1,266	16
17	Additional Sprinklers	2008	18,690		20	935	935	1,402	17
18									18
19	Emergency Generator	2009	28,398		20	710	710	710	19
20	Fire Damper Renovations	2009	176,785		20	4,420	4,420	4,420	20
21									21
22									22
23									23
24									24
25									25
26	<b>Current Year Booked Depreciation</b>			<b>19,476</b>			<b>(19,476)</b>		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,125,134	\$ 19,476		\$ 60,081	\$ 40,605	\$ 595,247	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	\$ 293,449	\$ 14,676	\$ 23,217	\$ 8,541		\$ 197,371	71
72	Current Year Purchases	113,518		5,676	5,676		5,676	72
73	Fully Depreciated Assets	349,248					349,248	73
74								74
75	TOTALS	\$ 756,215	\$ 14,676	\$ 28,893	\$ 14,217		\$ 552,295	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	N/A			\$	\$	\$	\$		\$	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)	\$ 1,881,349	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)	\$ 88,974	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 54,822	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,147,542	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Nationwide Health Properties

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>7/1/89</u>	\$ <u>152,044</u>	<u>10</u>	<u>40</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		123		\$ 152,044			7

10. Effective dates of current rental agreement:

Beginning 7/1/89

Ending 6/1/11

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

Fiscal Year Ending Annual Rent

12. 2010 \$ \_\_\_\_\_

13. 2011 \$ \_\_\_\_\_

14. 2012 \$ \_\_\_\_\_

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: \$ 11,744 Description: Medical Equip. (4,423); Dishwasher (910); Office Equip. (6,411)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center # 0045753 Report Period Beginning: 1/1/09 Ending: 12/31/09  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1,2)	5565	hrs	\$ 157,250			\$ 3,412	5,565	\$ 160,662	1
2	Licensed Speech and Language Development Therapist	10A(1,2)	1617	hrs	54,734			388	1,617	55,122	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1,2)	5768	hrs	215,615			823	5,768	216,438	4
5	Physician Care	39(3)		visits		1	75		1	75	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				130,499		130,499	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Oxygen &amp; Ambulance</u>	39(3)					20,820			20,820	12
13	Other (specify):										13
14	<b>TOTAL</b>				\$ 427,599	1	\$ 20,895	\$ 135,122	12,951	\$ 583,616	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: 1/1/09

Ending:

12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 13,357	\$ 13,357	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>146,707</u> )	548,600	548,600	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	137,873	137,873	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Resident Trust Bond</u>	225	225	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 700,055	\$ 700,055	10
<b>B. Long-Term Assets</b>				
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	573,002	1,125,134	15
16	Equipment, at Historical Cost	316,987	756,215	16
17	Accumulated Depreciation (book methods)	(218,530)	(1,147,542)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 671,459	\$ 733,807	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,371,514	\$ 1,433,862	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 516,964	\$ 516,964	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,944	191,944	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,192	3,192	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Schedule 17A</u>	685,557	685,557	36
37	<u>Due To/From Related Facilities</u>	1,672,325	1,672,325	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,069,982	\$ 3,069,982	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,069,982	\$ 3,069,982	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,698,468)	\$ (1,636,120)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,371,514	\$ 1,433,862	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

Litchfield Healthcare Center  
0045753  
12/31/2009

Schedule 17A

XV. BALANCE SHEET

Line 36: Other Current Liabilities (specify):

	<u>Operating</u>	<u>After Consolidation</u>
Accrued Insurance	353,662	353,662
Accrued Workers Compensation	131,881	131,881
Accrued Provider Assessment	12,340	12,340
Accrued Management Fees	187,674	187,674
	<u>685,557</u>	<u>685,557</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,219,084)	1
2	Restatements (describe):		2
3	Prior Period Adjustments	(57,354)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,276,438)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(422,030)	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)	\$ (422,030)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (1,698,468)	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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,597,140	1
2	Discounts and Allowances for all Levels	67,425	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,664,565</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	785,781	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 785,781</b>	8
<b>C. Other Operating Revenue</b>			
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	(165)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	179,147	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,846	19
20	Radiology and X-Ray	5,428	20
21	Other Medical Services	11,787	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 206,043</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>		26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>		29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 4,656,389</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	924,091	31
32	Health Care	2,279,382	32
33	General Administration	1,167,485	33
<b>B. Capital Expense</b>			
34	Ownership	275,208	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	365,833	35
36	Provider Participation Fee	66,420	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 5,078,419</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(422,030)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (422,030)</b>	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:

1/1/09

Ending:

12/31/09

**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	1,800	2,080	\$ 77,045	\$ 37.04	1
2	Assistant Director of Nursing	1,848	2,080	41,722	20.06	2
3	Registered Nurses	1,792	2,290	57,362	25.05	3
4	Licensed Practical Nurses	17,831	21,612	439,159	20.32	4
5	CNAs & Orderlies	55,286	62,519	885,894	14.17	5
6	CNA Trainees					6
7	Licensed Therapist	12,235	12,950	427,599	33.02	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,908	2,080	30,276	14.56	9
10	Activity Assistants	3,405	3,685	33,684	9.14	10
11	Social Service Workers	1,992	2,080	33,137	15.93	11
12	Dietician					12
13	Food Service Supervisor	1,873	2,080	33,433	16.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,573	16,107	156,148	9.69	15
16	Dishwashers					16
17	Maintenance Workers	5,110	5,484	55,953	10.20	17
18	Housekeepers	11,992	16,692	134,807	8.08	18
19	Laundry	6,541	7,043	58,511	8.31	19
20	Administrator	1,740	2,080	72,106	34.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,708	8,472	124,221	14.66	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 C: See SCH20A	7,476	8,432	125,806	14.92	32
33	Other(specify) <u>Marketing</u>	1,888	2,080	32,705	15.72	33
34	TOTAL (lines 1 - 33)	156,998	179,846	\$ 2,819,568 *	\$ 15.68	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	140	\$ 5,700	1(3)	35
36	Medical Director	72	24,000	9(3)	36
37	Medical Records Consultant	4	239	10(3)	37
38	Nurse Consultant	Monthly	70	10(3)	38
39	Pharmacist Consultant	Monthly	7,633	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	36	2,488	11(3)	44
45	Social Service Consultant	36	2,488	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	288	\$ 42,618		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	N/A	\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

**Litchfield Health Care Center**

**Provider #: 0045740**

**1/1/2009 to 12/31/2009**

**Schedule 20A**

	<u>Hours</u> <u>Worked</u>	<u>Hours</u> <u>Paid</u>	<u>Total</u> <u>Wages</u>	<u>Ave. Hrly.</u> <u>Wage</u>
XVIII. Staffing & Salary Costs				
Line 32 - Other				
MDS Coordinator	1,920	2,080	53,137	25.55
Unit Coordinator	3,752	4,080	49,932	12.24
Nursing Assistant	1,804	2,272	22,737	10.01
	<u>7,476</u>	<u>8,432</u>	<u>125,806</u>	<u>14.92</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Litchfield Healthcare Center

# 0045753

Report Period Beginning: 1/1/09

Ending: 12/31/09

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Mary Buffington	Administrator	0	\$ 72,106	Workers' Compensation Insurance	\$ 111,367	IDPH License Fee	\$		
				Unemployment Compensation Insurance	16,803	Advertising: Employee Recruitment	46		
				FICA Taxes	215,697	Health Care Worker Background Check			
				Employee Health Insurance	177,399	(Indicate # of checks performed <u>67</u> )	1,360		
				Employee Meals		Patient Background Checks	89 1,663		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	383		
				Employee Relations	1,918	Miscellaneous Dues & Subscriptions	639		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 72,106	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,091			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Family Senior Care - Management Fees			\$ 232,827	N/A			Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 232,827	TOTAL			\$	N/A	
C. Professional Services				G. Schedule of Travel and Seminar**					
Vendor/Payee	Type	Amount							
IT Management	Computer Maintenance	\$ 36,194				In-State Travel			
Adelpro LLC	Computer Maintenance	2,400				N/A			
IT Management	Data Processing	12,500				Seminar Expense			
Ivans Inc	Data Processing	9,743				N/A			
Hamlin & Burton Liability	Risk Management	1,000				Entertainment Expense		( )	
Duane Morris LLP	Legal	17,712				(agree to Sch. V, line 24, col. 8)			
Ferry & Associates	Engineering	3,963				TOTAL		\$	
Scharf Law Firm	Legal	500							
Moore Stephens Lovelace	Accounting	2,200							
RSM McGladrey	Accounting	6,450							
IT Management	Internet Services	2,800							
Payday USA	Payroll Processing	7,448							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 102,910						

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3							N/A					
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Litchfield Healthcare Center# 0045753Report Period Beginning: 1/1/09Ending: 12/31/09**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? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,530 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.
- (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? N/A Indicate the amount. \$ 0
- (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?  
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
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**