

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: 0050476

Facility Name: Coventry Living Center

Address: 612 West St. Mary's Street Sterling 61081
Number City Zip Code

County: Whiteside

Telephone Number: (815) 626-9020 Fax # (815) 626-6434

HFS ID Number:

Date of Initial License for Current Owners: 08/01/2009

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Michael W. Martin Telephone Number: (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) SEE ACCOUNTANTS' PREPARATION REPORT (Date) _____
(Print Name and Title) _____
(Firm Name & Address) McGladrey & Pullen, LLP
20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Coventry Living Center

0050476 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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>124</u>	Skilled (SNF)	<u>124</u>	<u>45,260</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>6</u>	Intermediate (ICF)	<u>6</u>	<u>2,190</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>47,450</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>13,937</u>	<u>5,239</u>	<u>10,277</u>	<u>29,453</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,937</u>	<u>5,239</u>	<u>10,277</u>	<u>29,453</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.07%

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 08/01/09

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 08/01/09 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 124 and days of care provided 7,734

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2011 Ending: 12/31/2011
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	165,180	40,546	19,167	224,893		224,893	(839)	224,054			1
2	Food Purchase		181,286		181,286		181,286		181,286			2
3	Housekeeping	109,763	16,936		126,699		126,699		126,699			3
4	Laundry	37,703	137	913	38,753		38,753		38,753			4
5	Heat and Other Utilities			122,641	122,641		122,641	2,932	125,573			5
6	Maintenance	80,736	35,254	105,674	221,664		221,664	3,226	224,890			6
7	Other (specify):*											7
8	TOTAL General Services	393,382	274,159	248,395	915,936		915,936	5,319	921,255			8
	B. Health Care and Programs											
9	Medical Director			15,115	15,115		15,115		15,115			9
10	Nursing and Medical Records	1,782,373	169,909	114,615	2,066,897		2,066,897		2,066,897			10
10a	Therapy	11,446	5,947	654,548	671,941		671,941		671,941			10a
11	Activities	63,501	2,541	10,331	76,373		76,373		76,373			11
12	Social Services	89,820	31		89,851		89,851		89,851			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,947,140	178,428	794,609	2,920,177		2,920,177		2,920,177			16
	C. General Administration											
17	Administrative	83,570		311,389	394,959		394,959	(283,239)	111,720			17
18	Directors Fees											18
19	Professional Services			54,368	54,368		54,368	8,414	62,782			19
20	Dues, Fees, Subscriptions & Promotions			37,294	37,294		37,294	(25,102)	12,192			20
21	Clerical & General Office Expenses	114,911	35,437	29,128	179,476		179,476	202,742	382,218			21
22	Employee Benefits & Payroll Taxes			385,726	385,726		385,726		385,726			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,465	2,465		2,465	1,192	3,657			24
25	Other Admin. Staff Transportation			79,249	79,249		79,249	(37,400)	41,849			25
26	Insurance-Prop.Liab.Malpractice			103,643	103,643		103,643	1,785	105,428			26
27	Other (specify):* HO Alloc Benefits							29,133	29,133			27
28	TOTAL General Administration	198,481	35,437	1,003,262	1,237,180		1,237,180	(102,475)	1,134,705			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,539,003	488,024	2,046,266	5,073,293		5,073,293	(97,156)	4,976,137			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			14,991	14,991		14,991	1,087	16,078			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24	24		24	4,737	4,761			32
33	Real Estate Taxes			53,740	53,740		53,740	145,822	199,562			33
34	Rent-Facility & Grounds			819,996	819,996		819,996		819,996			34
35	Rent-Equipment & Vehicles			25,880	25,880		25,880	9,304	35,184			35
36	Other (specify):*											36
37	TOTAL Ownership			914,631	914,631		914,631	160,950	1,075,581			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		244,964		244,964		244,964		244,964			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,264	60,264		60,264		60,264			42
43	Other (specify):* Non-Allow Costs			292,418	292,418		292,418	(292,418)				43
44	TOTAL Special Cost Centers		244,964	352,682	597,646		597,646	(292,418)	305,228			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,539,003	732,988	3,313,579	6,585,570		6,585,570	(228,624)	6,356,946			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
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	(6,408)	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	1,087	30		9
10	Interest and Other Investment Income	(1,318)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				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	(234,605)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,200)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	56,924	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (185,520)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(43,104)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (43,104)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (228,624)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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	TOTAL (C): (sum of lines 38-46)			\$		47

Coventry Living Center

ID#	0050476
Report Period Beginning:	1/1/2011
Ending:	12/31/2011

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Radiology-Other Contracted Services	\$ (6,636)	43	1
2	Lab-Contract Services	(24,951)	43	2
3	Marketing/Sales-Other Expense	(1,979)	43	3
4	Penalties/Fines	(1,504)	43	4
5				5
6	Vending Machine Revenue	(839)	1	6
7				7
8	Real Estate Tax adjustment	145,822	33	8
9	Removing Airplane Expenses	(37,400)	25	9
10				10
11	Advertising	(11,777)	43	11
12	Marketing/Sales-Emp Retirement	(76)	43	12
13	Promotional Advertising-Market	(493)	43	13
14	Non Reimbursable expenses	(17)	43	14
15	Non allowable Chamber dues	(25)	20	15
16	Reclassification of repair expense to building	(429)	6	16
17	Disallow Org costs	(2,772)	43	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	56,924		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Morris Sterling Holdings , LLC	100	Mountain Ridge Wellness Center	North Carolina	Coventry Cottages	Sterling, IL	Independent Liv.
		Clemmons Nursing & Rehab	North Carolina	Walnut Grove Cottage	Morris, IL	Independent Liv.
		Windsor Care Center	Kentucky	N100LW, LLC	Hickory, NC	Airplane entity
		Blounstown Health & Rehab	Florida	DMG Aero , LLC	Hickory, NC	Airplane entity
		Walnut Grove Village	Morris, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	\$ 311,389	WW Healthcare Consultants, LLC		\$	(311,389)	1
2	V	21	Salaries/Wages		WW Healthcare Consultants, LLC		161,267	161,267	2
3	V	27	Employee Benefits		WW Healthcare Consultants, LLC		29,133	29,133	3
4	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC		37,197	37,197	4
5	V	19	Professional Services		WW Healthcare Consultants, LLC		8,414	8,414	5
6	V	20	Dues/Subs/Licenses		WW Healthcare Consultants, LLC		3,073	3,073	6
7	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC		4,278	4,278	7
8	V	32	Interest		WW Healthcare Consultants, LLC		6,055	6,055	8
9	V	26	Insurance		WW Healthcare Consultants, LLC		1,785	1,785	9
10	V	6	Hardware costs		WW Healthcare Consultants, LLC		2,117	2,117	10
11	V	24	Travel		WW Healthcare Consultants, LLC		1,192	1,192	11
12	V								12
13	V								13
14	Total			\$ 311,389			\$ 254,511	\$ * (56,878)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance Repairs-Auto	\$	WW Healthcare Consultants, LLC		\$ 1,538	\$ 1,538	15
16	V	35	Rent		WW Healthcare Consultants, LLC		9,304	9,304	16
17	V	5	Utilities		WW Healthcare Consultants, LLC		2,932	2,932	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 13,774	\$ * 13,774	39

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

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	Steve Womack	Owner	Administrative	70.00	192,947	6.99	13.98	Salary	\$ 31,365	21(1)	1
2	Melvin Woodward	Owner	Administrative	30.00	129,266	6.99	13.98	Salary	21,014	21(1)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 52,379		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

Coventry Living Center
0050476
12/31/2011

Schedule 7A

Related Nursing Facilities

	Salaries		Hours Worked	% of Total Hours
	Steve Womack	Melvin Woodward		
Regency Care of Black Mountain	36,863	24,697	8.22	16.43%
Regency Care of Clemmons	29,248	19,595	6.52	13.04%
Regency Care of Mt. Sterling	52,156	34,943	11.63	23.25%
Regency Care of Blountstown	23,893	16,007	5.33	10.65%
Sterling SNF Management LLC	31,365	21,014	6.99	13.98%
Morris SNF Management	39,232	26,284	8.74	17.49%
BHI LLC	11,555	7,741	2.58	5.15%
	224,312	150,280	50.00	100.00%

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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 WW Healthcare Consultants, LLC
Street Address 1987 8th Avenue NW
City / State / Zip Code Hickory, NC 28601
Phone Number (828) 381-4923
Fax Number (828) 322-9598

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Salaries/Wages	Patient Days	156,062	7	\$ 1,153,319	\$ 1,153,319	21,822	\$ 161,267	1
2	27	Employee Benefits	Patient Days	156,062	7	208,351		21,822	29,133	2
3	21	Clerical/General-Other	Patient Days	156,062	7	266,020		21,822	37,197	3
4	19	Professional Services	Patient Days	156,062	7	60,171		21,822	8,414	4
5										5
6	20	Dues/Subs/Licenses	Patient Days	156,062	7	21,979		21,822	3,073	6
7										7
8	24	Travel/Seminar	Patient Days	156,062	7	8,528		21,822	1,192	8
9	21	Office/Other Supplies	Patient Days	156,062	7	30,594		21,822	4,278	9
10	32	Interest	Patient Days	156,062	7	43,304		21,822	6,055	10
11	26	Insurance	Patient Days	156,062	7	12,764		21,822	1,785	11
12	6	Hardware costs	Patient Days	156,062	7	15,141		21,822	2,117	12
13	6	Maintenance Repairs-Auto	Patient Days	156,062	7	10,999		21,822	1,538	13
14	35	Rent	Patient Days	156,062	7	66,539		21,822	9,304	14
15										15
16	5	Utilities	Patient Days	156,062	7	20,972		21,822	2,932	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,918,681	\$ 1,153,319		\$ 268,285	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Non allowable interest											24	6	
7													7	
8													8	
9	TOTAL Facility Related						\$					\$	24	9
	B. Non-Facility Related*													
10													10	
11							Interest income offset					(1,294)	11	
12							Disallow nonallowable interest					(24)	12	
13							Allocated from Home Office					6,055	13	
14	TOTAL Non-Facility Related						\$					\$	4,737	14
15	TOTALS (line 9+line14)						\$					\$	4,761	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

[illegible]

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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Coventry Living Center

COUNTY

Whiteside

FACILITY IDPH LICENSE NUMBER

0050476

CONTACT PERSON REGARDING THIS REPORT

Gene Woodward

TELEPHONE

(828) 322-4285

FAX #:

(828) 322-9598

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>11-16-151-003</u>	<u>Long-Term Care Property</u>	\$ <u>279,282.00</u>	\$ <u>199,282.00</u>
2.	<u>11- 16- 151- 002</u>	<u>Long-Term Care Property</u>	\$ <u>280.00</u>	\$ <u>280.00</u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u>279,562.00</u>	\$ <u>199,562.00</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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

43,700

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

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).

68 Cottages - Cost not included on cost report

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	N/A			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Coventry Living Center

0050476

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Plumbing		2009		5,076	338	15	339	1	763
10	Plumbing		2010		7,897	461	10	790	329	1,251
11	Mixing Valves		2009		3,305		15	220	220	477
12	Heater Repair		2010		3,450		5	690	690	1,035
13	Generator Repair		2010		4,331		5	866	866	1,299
14	Generator Repair		2010		2,981		5	596	596	894
15	TD Kurtz glass new door		2011		9,397		20	235	235	235
16	TD Kurtz glass new door		2011		9,297		20	232	232	232
17	Repairs-Carpet Service		2011		2,729		20	68	68	68
18	Repairs-Site inspection		2011		8,446		20	211	211	211
19	Repairs-Roofing power		2011		2,910		20	73	73	73
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Coventry Living Center

0050476

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66	To reconcile to financial statements		429	1,940			(1,940)		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 60,248	\$ 2,739		\$ 4,321	\$ 1,582	\$ 6,538	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 55,833	\$ 9,102	\$ 8,607	\$ (495)		\$ 18,737	71
72	Current Year Purchases	37,609	3,150	3,150			3,150	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 93,442	\$ 12,252	\$ 11,757	\$ (495)		\$ 21,887	75

D. Vehicle Costs. (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			\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$ 153,690
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 14,991
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 16,078
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 1,087
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 28,425

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	\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92	N/A	\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Wakefield Communities-Sterling
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:		130	08/2009	\$819,996			3
4	Additions							4
5								5
6								6
7	TOTAL		130		\$819,996			7

**

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$35,184
- Description:See Sch 14A

(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	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

Coventry Living Center
0050476
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Schedule 14A

#16

<u>Description</u>	<u>Amount</u>
Maintenance Equipment	20,217
Nurse Equipment	363
Dish Machine	1,800
HO Allocation-Rent(equip)	9,304
Other Rent/Lease Expense	3,500
Total Rental Exp.	<u>35,184</u>

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	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(3)	hrs	\$	5,311	\$ 289,803	\$ 1,043	5,311	\$ 290,846	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,241	62,044	790	1,241	62,834	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2),(3)	hrs		6,045	302,701	4,114	6,045	306,815	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				244,964		244,964	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(1)	359	11,446				359	11,446	13
14	TOTAL			\$ 11,446	12,597	\$ 654,548	\$ 250,911	12,956	\$ 916,905	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 199,137	\$ 199,137	1
2	Cash-Patient Deposits	20,308	20,308	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>476,892</u>)	1,126,663	1,126,663	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,959	15,959	6
7	Other Prepaid Expenses	19,115	19,115	7
8	Accounts Receivable (owners or related parties)	324,178	324,178	8
9	Other(specify): <u>Real Estate Tax Escrow</u>	155,745	155,745	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,861,105	\$ 1,861,105	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	45,306	60,248	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	93,442	93,442	16
17	Accumulated Depreciation (book methods)	(27,028)	(28,425)	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): _____	244,256	244,256	22
23	Other(specify): <u>See Sch 17</u>	151,686	151,686	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 507,662	\$ 521,207	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,368,767	\$ 2,382,312	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,376,674	\$ 2,376,674	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	20,308	20,308	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	185,205	185,205	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,100	3,100	35
	Other Current Liabilities(specify):			
36	See Sch 17	68,851	68,851	36
37	See Sch 17	863,681	863,681	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,517,819	\$ 3,517,819	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,517,819	\$ 3,517,819	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,149,052)	\$ (1,135,507)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,368,767	\$ 2,382,312	48

***(See instructions.)**

Coventry Living Center
0050476
12/31/2011

Schedule XV. Balance Sheet

Schedule 17A

Line 23	<u>After</u>	
	<u>Operating</u>	<u>Consolidation</u>
Capital Improvements Escrow	142,435	142,435
Deposits-Utilities	9,251	9,251
	<u>151,686</u>	<u>151,686</u>
Line 36		
W/H-State Income Tax	(132,847)	(132,847)
W/H-Group Insurance	16,788	16,788
General/Property/Liability Ins	(10,752)	(10,752)
Real estate taxes	57,960	57,960
	<u>(68,851)</u>	<u>(68,851)</u>
Line 37		
Receivables-Related Party	(20)	(20)
Due To Wakefield	(10,000)	(10,000)
Due To/From Morris SNF Mgt	(853,661)	(853,661)
	<u>(863,681)</u>	<u>(863,681)</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (815,648)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	20,033	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (795,615)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(353,437)	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) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (353,437)	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)	\$ (1,149,052)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,040,924	1
2	Discounts and Allowances for all Levels	(889,922)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,151,002	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,438,155	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,438,155	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	19	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	520,842	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,213	19
20	Radiology and X-Ray	529	20
21	Other Medical Services	68,476	21
22	Laundry	4,360	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 632,439	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,294	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,294	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19</u>	9,243	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,243	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,232,133	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	915,936	31
32	Health Care	2,920,177	32
33	General Administration	1,237,180	33
	B. Capital Expense		
34	Ownership	914,631	34
	C. Ancillary Expense		
35	Special Cost Centers	537,382	35
36	Provider Participation Fee	60,264	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,585,570	40
41	Income before Income Taxes (line 30 minus line 40)**	(353,437)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (353,437)	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 is a cash basis taxpayer.

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

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

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Schedule 19A

XVII. Income Statement
E. Line 28-Other Income

	Amount
Transportation - Private	1,430
Vending Machine Revenue	839
Other Revenue	6,974
	9,243

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	1,611	1,611	\$ 66,759	\$ 41.45	1
2	Assistant Director of Nursing	2,249	2,249	55,206	24.55	2
3	Registered Nurses	7,583	7,583	180,433	23.79	3
4	Licensed Practical Nurses	28,533	28,533	646,434	22.66	4
5	CNAs & Orderlies	67,814	67,814	665,748	9.82	5
6	CNA Trainees					6
7	Licensed Therapist	359	359	11,446	31.88	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,232	8,232	63,501	7.71	10
11	Social Service Workers	6,840	6,840	89,820	13.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,641	18,641	165,180	8.86	15
16	Dishwashers					16
17	Maintenance Workers	4,993	4,993	80,736	16.17	17
18	Housekeepers	13,257	13,257	109,763	8.28	18
19	Laundry	4,216	4,216	37,703	8.94	19
20	Administrator	2,386	2,386	83,570	35.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,845	6,845	114,911	16.79	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,487	1,487	26,396	17.75	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,084	2,084	22,614	10.85	31
32	Other Health Care <u>See Sch. 20A</u>	5,447	5,447	118,783	21.81	32
33	Other(specify) _____					33
34	TOTAL (lines 1 - 33)	182,574	182,574	\$ 2,539,003 *	\$ 13.91	34

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	260	\$ 15,828	1(3)	35
36	Medical Director	Monthly	15,115	9(3)	36
37	Medical Records Consultant	Monthly	954	10(3)	37
38	Nurse Consultant	975	91,140	10(3)	38
39	Pharmacist Consultant	Monthly	6,203	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	72	5,646	11(3)	44
45	Social Service Consultant				45
46	Other(specify) <u>Interim Administrator</u>	Monthly	28,150	17(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,306	\$ 163,036		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

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

** See instructions.

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Schedule 20A

Ln 32

Name	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salary</u>
MDS Coordinator	3,389	3,389	\$ 88,273
Central Supply	2,058	2,058	\$ 30,510
Total	5,447	5,447	118,783

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Robert Talbot	Administrator	0	\$ 10,612	Workers' Compensation Insurance		\$ 99,919	IDPH License Fee	\$ 1,990	
Donna Whaley	Administrator	0	72,958	Unemployment Compensation Insurance			Advertising: Employee Recruitment		
				FICA Taxes		222,517	Health Care Worker Background Check		
				Employee Health Insurance		48,531	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks	4,425	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Fees	2,562	
				Other Employee Benefits		14,759	Miscellaneous Dues & Subscriptions	142	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 83,570				Management Company	3,073	
B. Administrative - Other							Less: Public Relations Expense	()	
Description			Amount				Non-allowable advertising	()	
Management Fees (Eliminated in col. 7)			\$ 311,389				Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 311,389	TOTAL (agree to Schedule V, line 22, col.8)		\$ 385,726	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,192
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
Brian LaLonde, CPA	Accounting		\$ 1,100				Out-of-State Travel	\$	
Mary Huss	Legal		35	N/A					
WW Healthcare Consultants	Legal		1,764						
Williams Mullen	Legal		4,868				In-State Travel		
ADP, Inc	Payroll Processing		11,941						
MDI Achieve Inc-Quickcare	Data Processing		8,707						
COMS	Data Processing		16,500						
WW Healthcare Consultants	Data Processing		473				Seminar Expense	2,465	
Direct supply tel	Data Processing		77						
Mc Gladrey, Pullen	Accounting		4,940						
Mcgladrey & Pullen	Bookkeeping		950				Management Company	1,192	
Sch 21A	Other proffessional service		3,013				Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 54,368				TOTAL	\$ 3,657	

*** Attach copy of IMRF notifications**

****See instructions.**

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Schedule 21A

C. Professional Fees

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Orthopedic Specialist	Other professional services	142
Rockford Orthopedic	Other professional services	171
Govig & Associate	Other professional services	2700
Total to P21C		<u>3,013</u>

TOTAL (agree to Schedule V, line 19, column 3) 54,368

Allocation: Home Office -Professional Fees 8,414
TOTAL (agree to Schedule V, line 19, column 8) 62,782

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?

N/A

What was the average life used for new equipment added during this period?

N/A

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

17,188

Line

10(2)

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

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.

\$

60,264

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?

No

Indicate the amount.

\$

N/A

(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?

N/A

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?

No

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 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.