FOR BHF USE

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 (Number) Sterling (City) 61081 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 1/1/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey 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: 1/1/2012 Ending: 12/31/2012

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	124	Skilled (SNF)	124	45,384	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	6	Sheltered Care (SC)	6	2,196	5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,580	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,250	4,959	10,624	29,833	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		1,325		1,325	12
13	DD 16 OR LESS					13
14	TOTALS	14,250	6,284	10,624	31,158	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.49%

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 [X] 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 [X]

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 [X] Date 08/01/09 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 124 and days of care provided 8,437

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Coventry Living Center # 0050476 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	177,350	46,136	15,091	238,577		238,577		238,577			1
2	Food Purchase		166,257		166,257		166,257	(165)	166,092			2
3	Housekeeping	144,555	22,584	1,037	168,176		168,176		168,176			3
4	Laundry	40,818	7,931	64	48,813		48,813		48,813			4
5	Heat and Other Utilities			112,719	112,719		112,719	3,169	115,888			5
6	Maintenance	85,489	23,855	65,659	175,003		175,003	(2,153)	172,850			6
7	Other (specify):*											7
8	**TOTAL General Services**	448,212	266,763	194,570	909,545		909,545	851	910,396			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,963,847	175,085	19,492	2,158,424		2,158,424		2,158,424			10
10a	Therapy											10a
11	Activities	50,576	4,017	10,811	65,404		65,404		65,404			11
12	Social Services	80,230			80,230		80,230		80,230			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,094,653	179,102	48,303	2,322,058		2,322,058		2,322,058			16
	C. General Administration											
17	Administrative	89,152		345,616	434,768		434,768	(345,616)	89,152			17
18	Directors Fees											18
19	Professional Services			64,650	64,650		64,650	16,714	81,364			19
20	Dues, Fees, Subscriptions & Promotions			24,621	24,621		24,621	609	25,230			20
21	Clerical & General Office Expenses	102,313	25,388	33,658	161,359		161,359	204,298	365,657			21
22	Employee Benefits & Payroll Taxes			464,936	464,936		464,936		464,936			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,666	4,666		4,666	1,657	6,323			24
25	Other Admin. Staff Transportation			41,501	41,501		41,501		41,501			25
26	Insurance-Prop.Liab.Malpractice			108,278	108,278		108,278	2,555	110,833			26
27	Other (specify):* HO Alloc Benefits							28,384	28,384			27
28	**TOTAL General Administration**	191,465	25,388	1,087,926	1,304,779		1,304,779	(91,399)	1,213,380			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,734,330	471,253	1,330,799	4,536,382		4,536,382	(90,548)	4,445,834			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Coventry Living Center #0050476 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			17,825	17,825		17,825	2,704	20,529			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							4,896	4,896			32
33	Real Estate Taxes			83,962	83,962		83,962		83,962			33
34	Rent-Facility & Grounds			745,217	745,217		745,217		745,217			34
35	Rent-Equipment & Vehicles			13,313	13,313		13,313	5,533	18,846			35
36	Other (specify):*											36
37	**TOTAL Ownership**			860,317	860,317		860,317	13,133	873,450			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	10,876	247,729	839,625	1,098,230		1,098,230		1,098,230			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			216,883	216,883		216,883		216,883			42
43	Other (specify):* Non-Allowable Cos			439,256	439,256		439,256	(439,256)				43
44	**TOTAL Special Cost Centers**	10,876	247,729	1,495,764	1,754,369		1,754,369	(439,256)	1,315,113			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,745,206	718,982	3,686,880	7,151,068		7,151,068	(516,671)	6,634,397			45

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

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	(165)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,575)	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	175	30		9
10	Interest and Other Investment Income	(984)	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	(396,337)	43		24
25	Fund Raising, Advertising and Promotional	(1,745)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(48,231)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (453,862)		$	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)	(62,809)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (62,809)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (516,671)		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

STATE OF ILLINOIS **Page 5A**

Coventry Living Center

ID# **0050476**

Report Period Beginning: **1/1/2012**

Ending: **12/31/2012**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Radiology-Other Contracted Services	$ (7,505)	43	1
2	Lab-Contract Services	(20,603)	43	2
3	Marketing/Sales-Other Expense	(2,754)	43	3
4	Penalties/Fines	(4,835)	43	4
5	Capitalize Repair & Maintenance	(3,468)	6	5
6	Promotional Advertising-Market	(647)	43	6
7	Offset Other Income Against A&G - Other	(8,419)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(48,231)		49

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	Regency Care of Mountain Ridge	North Carolina	Coventry Cottages	Sterling, IL	Independent Liv.
		Regency Care of Clemmons	North Carolina	Walnut Grove Cottage	Morris, IL	Independent Liv.
		Regency Care of Mount Sterling	Kentucky	N100LW, LLC	Hickory, NC	Airplane entity
		Regency Care of Blountstown	Florida	DMG Aero , LLC	Hickory, NC	Airplane entity
		Walnut Grove Village	Morris, IL	Regency Holdings LLC	Hickory, NC	Holding Co.
				SCK Assurance LLC	Hickory, NC	Insurance Co.

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 345,616	WW Healthcare Consultants, LLC	100.00%	$	$ (345,616)	1
2	V	21	Salaries/Wages		WW Healthcare Consultants, LLC	100.00%	193,143	193,143	2
3	V	27	Employee Benefits		WW Healthcare Consultants, LLC	100.00%	28,384	28,384	3
4	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC	100.00%	19,310	19,310	4
5	V	19	Professional Services		WW Healthcare Consultants, LLC	100.00%	16,714	16,714	5
6	V	30	Depreciation		WW Healthcare Consultants, LLC	100.00%	2,529	2,529	6
7	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC	100.00%	264	264	7
8	V	32	Interest		WW Healthcare Consultants, LLC	100.00%	5,880	5,880	8
9	V	26	Insurance		WW Healthcare Consultants, LLC	100.00%	2,555	2,555	9
10	V	6	Maintenance & Repair - Other		WW Healthcare Consultants, LLC	100.00%	1,315	1,315	10
11	V	24	Travel		WW Healthcare Consultants, LLC	100.00%	1,657	1,657	11
12	V	35	Equipment Rent		WW Healthcare Consultants, LLC	100.00%	5,533	5,533	12
13	V	5	Utilities		WW Healthcare Consultants, LLC	100.00%	3,169	3,169	13
14	Total			$ 345,616			$ 280,453	$ * (65,163)	14

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

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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. [x] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Licenses	$	WW Healthcare Consultants, LLC	100.00%	$ 2,354	$ 2,354	15
16	V								16
17	V								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			$			$ 2,354	$ * 2,354	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: 1/1/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	Insurance	$ 84,012	SCK assurance LLC		$ 84,012	$	15
16	V								16
17	V								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			$ 84,012			$ 84,012	$ *	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: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6		Note : No owners received compensation from this facility.									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

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Salaries/Wages	Patient Days	209,058	6	$ 1,295,914	$ 1,295,914	31,158	$ 193,143	1
2	6	Maintenance Repairs-Auto	Patient Days	209,058	6	8,826		31,158	1,315	2
3	21	Clerical/General-Other	Patient Days	209,058	6	129,562		31,158	19,310	3
4	19	Professional Services	Patient Days	209,058	6	112,145		31,158	16,714	4
5	27	Other - Employee Benefits	Patient Days	209,058	6	190,444		31,158	28,384	5
6	5	Utilities	Patient Days	209,058	6	21,261		31,158	3,169	6
7	30	Depreciation	Patient Days	209,058	6	16,970		31,158	2,529	7
8	24	Travel/Seminar	Patient Days	209,058	6	11,115		31,158	1,657	8
9	21	Clerical/General-Supplies	Patient Days	209,058	6	1,771		31,158	264	9
10	32	Interest	Patient Days	209,058	6	39,451		31,158	5,880	10
11	26	Insurance	Patient Days	209,058	6	17,143		31,158	2,555	11
12	35	Rent	Patient Days	209,058	6	37,122		31,158	5,533	12
13	20	Licenses	Patient Days	209,058	6	15,794		31,158	2,354	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					$ 1,897,518	$ 1,295,914		$ 282,807	25

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: SCK assurance LLC
Street Address: 1978 8th Avenue NW
City / State / Zip Code: Hickory, NC 28601
Phone Number: (828) 381-4923
Fax Number: (828) 322-9598

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Cost			$	$		$ 84,012	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					$	$		$ 84,012	25

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Wakefield Communities-		X	Rent in arrears	demand	7/01/2011	375,832	375,832	demand	zero %		6
7	Sterling											7
8	Nonallowable finance charges		X								24	8
9	TOTAL Facility Related						$ 375,832	$ 375,832			$ 24	9
	B. Non-Facility Related*											
10												10
11							Interest income offset				(984)	11
12							Disallow nonallowable interest				(24)	12
13							Allocated from Home Office				5,880	13
14	TOTAL Non-Facility Related						$	$			$ 4,872	14
15	TOTALS (line 9+line14)						$ 375,832	$ 375,832			$ 4,896	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.)

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2011	$ 255,575	2
3. Under or (over) accrual (line 2 minus line 1).		$ 255,575	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	**Cottage Taxes -Non Allowable**	(171,613)	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 83,962	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	147,750	8
	2008	205,514	9
	2009	271,648	10
	2010	279,562	11
	2011	255,575	12

Facility does not accrue real estate taxes.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 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) 381-4923 FAX #: Please call - faxes may not be received.

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-16-151-003	Long-Term Care Property	$ 255,300.00	$ 83,687.00
2.	11-16-151-002	Long-Term Care Property	$ 275.00	$ 275.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 255,575.00	$ 83,962.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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. [X] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Plumbing			2009	5,076	338	15	339	1	1,102	9
10	Plumbing			2010	7,897	790	10	790	(0)	2,041	10
11	Mixing Valves			2009	3,305		15	220	220	697	11
12	Heater Repair			2010	3,450		5	690	690	1,725	12
13	Generator Repair			2010	4,331		5	866	866	2,165	13
14	Generator Repair			2010	2,981		5	596	596	1,490	14
15	TD Kurtz glass new door			2011	9,397	470	20	470		705	15
16	TD Kurtz glass new door			2011	9,297	135	20	464	329	696	16
17	Repairs-Carpet Service			2011	2,729		20	136	136	204	17
18	Repairs-Site inspection			2011	8,446		20	422	422	633	18
19	Repairs-Roofing power			2011	2,910		20	146	146	219	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28	To reconcile to financial statements					1,364			(1,364)		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: 1/1/2012 Ending: 12/31/2012

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									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 59,819	$ 3,097		$ 5,139	$ 2,042	$ 11,677	70

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

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	$ 93,442	$ 12,558	$ 11,345	$ (1,213)		$ 33,232	71
72	Current Year Purchases	22,682	2,170	1,516	(654)		1,516	72
73	Fully Depreciated Assets							73
74	Management Company Allocation			2,529	2,529			74
75	TOTALS	$ 116,124	$ 14,728	$ 15,390	$ 662		$ 34,748	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			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 175,943	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 17,825	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,529	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,704	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 46,425	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.

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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. [X] 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	$ 745,217			3
4	Additions							4
5								5
6								6
7	TOTAL		130		$ 745,217 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 01/01/2010
    Ending 03/31/2025

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

	Fiscal Year Ending	Annual Rent
12.	01/01/2013	$ 762,000
13.	01/01/2014	$ 798,000
14.	01/01/2015	$ 798,000

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 18,846 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

* 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.

Schedule 14A

Line B, 16

Description	Amount
Maintenance Equipment	8,230
Nurse Equipment	108
Dish Machine	2,475
HO Allocation-Rent(equip)	5,533
Other Rent/Lease Expense	2,500
Total Rental Exp.	18,846

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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
   - [X] 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.

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	39(2),(3)	hrs	$	6,242	$ 367,610	$	6,242	$ 367,610	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,436	79,399		1,436	79,399	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3)	hrs		8,505	392,616	2,088	8,505	394,704	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				245,405		245,405	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Pharmacy Expense	39(2)					675		675	12
13	Other (specify): Respiratory Therapy	39(1),(2)	473	10,876			236	473	11,112	13
14	TOTAL			$ 10,876	16,183	$ 839,625	$ 248,404	16,656	$ 1,098,905	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.

STATE OF ILLINOIS

Facility Name & ID Number Coventry Living Center **#** 0050476 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 **(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	$ 208,611	$ 208,611	1
2	Cash-Patient Deposits	12,745	12,745	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 673,702)	1,663,180	1,663,180	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,621	17,621	6
7	Other Prepaid Expenses	27,317	27,317	7
8	Accounts Receivable (owners or related parties)	520,020	520,020	8
9	Other(specify): See Schedule 17A	452,852	452,852	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,902,346	$ 2,902,346	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	59,819	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	112,656	116,124	16
17	Accumulated Depreciation (book methods)	(44,853)	(46,425)	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 (spe **Const in Progress**	251,685	251,685	22
23	Other(specify): See Schedule 17A	27,826	27,826	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 392,620	$ 409,029	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,294,966	$ 3,311,375	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,079,962	$ 1,079,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,745	12,745	28
29	Short-Term Notes Payable	375,832	375,832	29
30	Accrued Salaries Payable	228,186	228,186	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	467,057	467,057	36
37	See Schedule 17A	1,432,681	1,432,681	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,596,463	$ 3,596,463	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)**	$ 3,596,463	$ 3,596,463	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (301,497)	$ (285,088)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,294,966	$ 3,311,375	48

***(See instructions.)**

Coventry Living Center
0050476
12/31/2012

Schedule XV. Balance Sheet

			Schedule 17A
		Operating	After Consolidation
Line 9	Real Estate Tax Escrow	440,906	440,906
	Underwithheld Group Insurance	7,269	7,269
	Due from Employee Advances	4,677	4,677
		452,852	452,852
Line 23	Capital Improvements Escrow	18,575	18,575
	Deposits-Utilities	9,251	9,251
		27,826	27,826
Line 36			
	Accrued PTO	144,936	144,936
	Due to Medicaid/Medicare Audit	56,435	56,435
	General/Property/Liability Ins	10,752	10,752
	Worker's Comp Liability	33,187	33,187
	Health Savings Account	145	145
	Real Estate Taxes	221,602	221,602
		467,057	467,057
Line 37			
	Receivables-Related Party	20	20
	Due To Wakefield	262,000	262,000
	Due To/From Morris SNF Mgt	1,170,661	1,170,661
		1,432,681	1,432,681

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,149,052)	1
2	Restatements (describe):		2
3			3
4	See Schedule 18A	1,086,317	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (62,735)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(238,762)	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)**	$ (238,762)	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)**	$ (301,497)	24 *

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

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,683,894	1
2	Discounts and Allowances for all Levels	(2,363,026)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,320,868	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,381,456	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,381,456	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	120	13
14	Non-Patient Meals	165	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	679,102	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,844	19
20	Radiology and X-Ray	13,840	20
21	Other Medical Services	464,742	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,199,813	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	984	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 984	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	9,185	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,185	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,912,306	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	909,545	31
32	Health Care	2,322,058	32
33	General Administration	1,304,779	33
	B. Capital Expense		
34	Ownership	860,317	34
	C. Ancillary Expense		
35	Special Cost Centers	1,537,486	35
36	Provider Participation Fee	216,883	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,151,068	40
41	**Income before Income Taxes (line 30 minus line 40)****	(238,762)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (238,762)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,561,051	44
45	Private Pay - Net Inpatient Revenue	842,456	45
46	Medicare - Net Inpatient Revenue	1,655,305	46
47	Other-(specify) See Schedule 19A	288,772	47
48	Other-(specify) Other Contractual Allowances	(2,026,716)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,320,868	49

* **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.**

*** **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.**

^ - This entity is a cash basis taxpayer.

XVII. Income Statement

E. Line 28-Other Income

	Amount
Vending Machine Revenue	766
Other Revenue	8,419
	9,185

Line 47 - Other revenue defined by payor source

Managed Care & Retro Revenue	6,348
Hospice	282,424
	288,772

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,168	2,266	$ 61,534	$ 27.16	1
2	Assistant Director of Nursing	1,509	1,509	44,554	29.53	2
3	Registered Nurses	4,898	5,259	142,218	27.04	3
4	Licensed Practical Nurses	30,768	32,972	797,567	24.19	4
5	CNAs & Orderlies	63,917	67,665	676,251	9.99	5
6	CNA Trainees					6
7	Licensed Therapist	560	589	10,876	18.47	7
8	Rehab/Therapy Aides	3,435	4,085	44,454	10.88	8
9	Activity Director					9
10	Activity Assistants	5,882	6,100	50,576	8.29	10
11	Social Service Workers	5,322	5,575	80,230	14.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,853	17,991	177,350	9.86	15
16	Dishwashers					16
17	Maintenance Workers	5,501	5,739	85,489	14.90	17
18	Housekeepers	14,844	15,665	144,555	9.23	18
19	Laundry	3,773	4,090	40,818	9.98	19
20	Administrator	2,048	2,070	89,152	43.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,261	5,624	102,313	18.19	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	1,955	2,108	25,851	12.26	31
32	Other Health CSee Sch. 20A	8,110	8,471	171,418	20.24	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	176,804	187,778	$ 2,745,206 *	$ 14.62	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	279	$ 14,343	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant	Quarterly	1,908	10(3)	37
38	Nurse Consultant	54	7,297	10(3)	38
39	Pharmacist Consultant	Monthly	5,673	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	75	4,768	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	408	$ 51,989		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	231	4,614	10(3)	52
53	TOTAL (lines 50 - 52)	231	$ 4,614		53

Coventry Living Center
0050476
12/31/2012

Schedule 20A

Ln 32 - Other Health Care

Name	Hours Worked	Hours Paid	Salary	AHW
MDS Coordinator	4,256	4,338	$ 111,259	$ 25.65
Staffing Coordinato	2,080	2,080	$ 27,619	$ 13.28
Central Supply	1,774	2,053	$ 32,540	$ 15.85
Total	8,110	8,471	$ 171,418	20.24

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Talbot	Administrator	0	$ 22,288
Donna Whaley	Administrator	0	66,864
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,152

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in col. 7)	$ 345,616
TOTAL (agree to Schedule V, line 17, col. 3)	$ 345,616
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Brian LaLonde, CPA	Accounting	$ 3,125
WW Healthcare Consultants	Accounting	944
Emdeon Business	Data processing	267
Nebo	Data processing	100
ADP, Inc	Payroll Processing	23,112
MDI Achieve Inc-Quickcare	Data Processing	10,160
COMS	Data Processing	18,101
WW Healthcare Consultants	Data Processing	236
Ogletree, Deakins	Legal	500
McGladrey LLP	Accounting	5,915
Sch 21C	Other professional service	2,190
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 64,650

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 102,484
Unemployment Compensation Insurance	84,554
FICA Taxes	210,008
Employee Health Insurance	50,521
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	17,369
TOTAL (agree to Schedule V, line 22, col.8)	$ 464,936

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	12,727
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 414	4,973
Miscellaneous Licenses & Fees	2,753
Miscellaneous Dues & Subscriptions	433
Allocated from Home Office	2,354
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,230

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,666
Management Company Allocation	1,657
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,323

**See instructions.

Coventry Living Center
0050476
12/31/2012

Schedule 21A

C. Professional Fees

Vendor/Payee	Type	Amount
Orthopedic Specialist	Other professional services	45
Rockford Orthopedic	Other professional services	993
Northern Illinois Rehab	Other professional services	948
Heart Care Centers	Other professional services	204
	Total to P21C	2,190
	TOTAL (agree to Schedule V, line 19, column 3)	64,650
	Allocation: Home Office -Accounting Fees	4,089
	Allocation: Home Office -Legal Fees	12,625
	TOTAL (agree to Schedule V, line 19, column 8)	81,364

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3										N/A			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Coventry Living Center **#** 0050476 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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. $ **21,158** 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. $ **216,883**
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? **Yes** Indicate the amount. $ **165**

(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 of Schedule V? **Yes**

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