



Facility Name & ID Number Coventry Living Center

# 0050476 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

**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		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>6</u>	Sheltered Care (SC)	<u>6</u>	<u>2,190</u>	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>13,228</u>	<u>8,919</u>	<u>9,983</u>	<u>32,130</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>373</u>		<u>373</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,228</u>	<u>9,292</u>	<u>9,983</u>	<u>32,503</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.50%

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 6,779

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name &amp; ID Number

Coventry Living Center

# 0050476

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	189,787	42,167	10,772	242,726		242,726		242,726		1
2	Food Purchase		182,884		182,884		182,884	(1,307)	181,577		2
3	Housekeeping	145,650	22,836	1,000	169,486		169,486		169,486		3
4	Laundry	54,587	14,031		68,617		68,617		68,617		4
5	Heat and Other Utilities			128,976	128,976		128,976	3,138	132,114		5
6	Maintenance	75,231	28,029	85,425	188,685		188,685	(29,440)	159,245		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	465,254	289,947	226,173	981,374		981,374	(27,609)	953,765		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,993,371	169,761	34,686	2,197,818		2,197,818		2,197,818		10
10a	Therapy										10a
11	Activities	58,537	3,632	6,910	69,079		69,079		69,079		11
12	Social Services	56,444		748	57,191		57,191		57,191		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,108,352	173,393	60,343	2,342,089		2,342,089		2,342,089		16
	<b>C. General Administration</b>										
17	Administrative	84,559		328,980	413,539		413,539	(328,980)	84,559		17
18	Directors Fees										18
19	Professional Services			108,250	108,250		108,250	21,150	129,400		19
20	Dues, Fees, Subscriptions & Promotions			25,905	25,905		25,905	(5,371)	20,534		20
21	Clerical & General Office Expenses	128,506	22,276	28,891	179,674		179,674	272,658	452,332		21
22	Employee Benefits & Payroll Taxes			484,745	484,745		484,745		484,745		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,365	1,365		1,365	10,970	12,335		24
25	Other Admin. Staff Transportation			23,386	23,386		23,386		23,386		25
26	Insurance-Prop.Liab.Malpractice			139,985	139,985		139,985	33,834	173,819		26
27	Other (specify):* <b>HO Alloc Benefits</b>							1,995	1,995		27
28	<b>TOTAL General Administration</b>	213,065	22,276	1,141,507	1,376,849		1,376,849	6,256	1,383,106		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,786,671	485,617	1,428,024	4,700,312		4,700,312	(21,353)	4,678,959		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: 01/01/2013 Ending: 12/31/2013

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			32,210	32,210		32,210	(3,028)	29,182			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							8,821	8,821			32
33	Real Estate Taxes			108,000	108,000		108,000		108,000			33
34	Rent-Facility & Grounds			762,000	762,000		762,000		762,000			34
35	Rent-Equipment & Vehicles			2,505	2,505		2,505	5,575	8,080			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			904,715	904,715		904,715	11,368	916,083			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,009	593,889	801,898		801,898		801,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			223,029	223,029		223,029		223,029			42
43	Other (specify):* <b>Non-Allowable Co</b>			111,601	111,601		111,601	(111,601)	0			43
44	<b>TOTAL Special Cost Centers</b>		208,009	928,519	1,136,528		1,136,528	(111,601)	1,024,927			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,786,671	693,625	3,261,258	6,741,555		6,741,555	(121,585)	6,619,970			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: 01/01/2013

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**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,307)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,805)	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	(5,794)	30		9
10	Interest and Other Investment Income	(14,921)	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	(70,000)	43		24
25	Fund Raising, Advertising and Promotional				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	(83,164)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (181,991)		\$	30

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

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	60,406		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 60,406		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (121,585)		37

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

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

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

Coventry Living Center

ID# 0050476

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Radiology-Other Contracted Services	\$ (9,835)	43	1
2	Lab-Contract Services	(18,127)	43	2
3	Marketing/Sales-Other Expense	(4,556)	43	3
4	Penalties/Fines	(3,871)	43	4
5	Capitalize Repair & Maintenance	(33,237)	6	5
6	Promotional Advertising-Market	(6,093)	43	6
7	Offset Other Income Against A&G - Other	(9,619)	21	7
8	To adjust improvement under \$2,500	2,174	6	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	<b>Total</b>		(83,164)	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	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.  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	\$ 328,980	WW Healthcare Consultants, LLC	100.00%	\$	\$ (328,980)	1
2	V	21 Salaries/Wages		WW Healthcare Consultants, LLC	100.00%	204,965	204,965	2
3	V	27 Employee Benefits		WW Healthcare Consultants, LLC	100.00%	1,995	1,995	3
4	V	21 Clerical/General-Other		WW Healthcare Consultants, LLC	100.00%	69,410	69,410	4
5	V	19 Professional Services		WW Healthcare Consultants, LLC	100.00%	21,150	21,150	5
6	V	30 Depreciation		WW Healthcare Consultants, LLC	100.00%	2,766	2,766	6
7	V	21 Office/Other Supplies		WW Healthcare Consultants, LLC	100.00%	7,902	7,902	7
8	V	32 Interest		WW Healthcare Consultants, LLC	100.00%	23,742	23,742	8
9	V	26 Insurance		WW Healthcare Consultants, LLC	100.00%	33,834	33,834	9
10	V	6 Maintenance & Repair - Other		WW Healthcare Consultants, LLC	100.00%	1,623	1,623	10
11	V	24 Travel		WW Healthcare Consultants, LLC	100.00%	10,970	10,970	11
12	V	35 Equipment Rent		WW Healthcare Consultants, LLC	100.00%	5,575	5,575	12
13	V	5 Utilities		WW Healthcare Consultants, LLC	100.00%	3,138	3,138	13
14	Total		\$ 328,980			\$ 387,070	\$ * 58,090	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	20 Licenses	\$	WW Healthcare Consultants, LLC	100.00%	\$ 722	\$	722	15
16	V	43 Other Costs		WW Healthcare Consultants, LLC	100.00%	1,594		1,594	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		\$			\$ 2,316	\$ *	2,316	39

\* 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	26 Insurance	\$ 129,117	SCK Assurance LLC		\$ 129,117	\$	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		\$ 129,117			\$ 129,117	\$ *	0	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: 01/01/2013 Ending: 12/31/2013

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7	Note : No owners received compensation from this facility.										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: 01/01/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	Salaries/Wages	Patient Days	211,810	6	\$ 1,335,677	\$ 1,335,677	32,503	\$ 204,964	1
2	6	Maintenance Repairs-Auto	Patient Days	211,810	6	10,580	32,503	1,624	2	
3	21	Clerical/General-Other	Patient Days	211,810	6	452,321	32,503	69,410	3	
4	19	Professional Services	Patient Days	211,810	6	137,826	32,503	21,150	4	
5	27	Other - Employee Benefits	Patient Days	211,810	6	220,485	32,503	33,834	5	
6	5	Utilities	Patient Days	211,810	6	20,446	32,503	3,138	6	
7	30	Depreciation	Patient Days	211,810	6	18,022	32,503	2,766	7	
8	24	Travel/Seminar	Patient Days	211,810	6	71,487	32,503	10,970	8	
9	21	Clerical/General-Supplies	Patient Days	211,810	6	51,495	32,503	7,902	9	
10	32	Interest	Patient Days	211,810	6	154,714	32,503	23,741	10	
11	26	Insurance	Patient Days	211,810	6	12,999	32,503	1,995	11	
12	35	Rent	Patient Days	211,810	6	36,327	32,503	5,575	12	
13	20	Licenses	Patient Days	211,810	6	4,704	32,503	722	13	
14	43	Other Costs	Patient Days	211,810	6	10,388	32,503	1,594	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 2,537,471	\$ 1,335,677	\$ 389,385	25	

Facility Name & ID Number Coventry Living Center

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Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	26	Insurance	Direct Cost		\$	\$		\$ 129,117	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				\$	\$		\$ 129,117	25



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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 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.)	2012			\$	2
					252,653
3. Under or (over) accrual (line 2 minus line 1).				\$	3
					252,653
4. Real Estate Tax accrual used for 2013 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$	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		(144,653)
<b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	7
					108,000
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>205,514</u>	8		
	2009	<u>271,648</u>	9		
	2010	<u>279,562</u>	10		
	2011	<u>255,575</u>	11		
	2012	<u>252,653</u>	12		
<u>Facility does not accrue real estate taxes.</u>					
				<b>FOR BHF USE ONLY</b>	
				13	13
				14	14
				15	15
				16	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.**

## 2012 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 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-16-151-003</u>	<u>Long-Term Care Property</u>	\$ <u>252,381.00</u>	\$ <u>107,728.00</u>
2. <u>11-16-151-002</u>	<u>Long-Term Care Property</u>	\$ <u>272.00</u>	\$ <u>272.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>252,653.00</u></u>	\$ <u><u>108,000.00</u></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?      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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	3

**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	
<b>Improvement Type**</b>										
9	Plumbing		2009	5,076	338	15	339	1	1,441	9
10	Plumbing		2010	7,897	790	10	790	(0)	2,831	10
11	Mixing Valves		2009	3,305		15	220	220	917	11
12	Heater Repair		2010	3,450		5	690	690	2,415	12
13	Generator Repair		2010	4,331		5	866	866	3,031	13
14	Generator Repair		2010	2,981		5	596	596	2,086	14
15	TD Kurtz glass new door		2011	9,397	470	20	470		1,175	15
16	TD Kurtz glass new door		2011	9,297	327	20	464	137	1,160	16
17	Repairs-Carpet Service		2011	2,729		20	136	136	340	17
18	Repairs-Site inspection		2011	8,446		20	422	422	1,055	18
19	Repairs-Roofing power		2011	2,910		20	146	146	365	19
20										20
21	New Heat Exchanger		2013	8,700	445	10	435	(10)	435	21
22	Replace Existing Water Soure Heat Pumps		2013	48,785	11,868	10	2,439	(9,429)	2,439	22
23	HVAC		2013	2,500	21	10	125	104	125	23
24	Interior Design Fee		2013	4,400	37	10	220	183	220	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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)	\$ 124,204	\$ 14,296		\$ 8,358	\$ (5,938)	\$ 20,035	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	\$ 116,684	\$ 5,390	\$ 15,533	\$ 10,143	10	\$ 50,281	71
72	Current Year Purchases	45,588	12,524	2,525	(9,999)	10	2,525	72
73	Fully Depreciated Assets							73
74	Management Company Allocation			2,766	2,766			74
75	TOTALS	\$ 162,272	\$ 17,914	\$ 20,824	\$ 2,910		\$ 52,806	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)	\$ 286,476	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,210	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,182	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,028)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 72,841	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.

**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	\$ 762,000			3
4	Additions							4
5								5
6								6
7	TOTAL		130		\$ 762,000			7

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. 2014 \$ 798,000

13. 2015 \$ 798,000

14. 2016 \$ 798,000

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: \$ 8,080 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.

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Schedule 14A

Line B, 16

<u>Description</u>	<u>Amount</u>
Maintenance Equipment	30
Dish Machine	2,475
HO Allocation-Rent(equip)	5,575
Total Rental Exp.	<u>8,080</u>

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 01/01/2013 Ending: 12/31/2013  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides.                  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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



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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	39(3)	hrs	\$	4,518	\$	260,023	\$	4,518	\$	260,023	1	
2	Licensed Speech and Language Development Therapist	39(3)	hrs		1,070		60,680		1,070		60,680	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	39(2),(3)	hrs		6,465		273,186		6,465		274,390	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 prescripts						205,757		205,757	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10	
11	Academic Education		hrs									11	
12	Other (specify): <u>Non Capitalized Equip</u>	39(2)							1,041		1,041	12	
13	Other (specify): <u>Respiratory Therapy</u>	39(2)							7		7	13	
14	TOTAL			\$	12,053	\$	593,889	\$	208,009	12,053	\$	801,898	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Coventry Living Center# 0050476Report Period Beginning: 01/01/2013Ending: 12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 27,771	\$ 27,771	1
2	Cash-Patient Deposits	13,462	13,462	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>218,269</u> )	1,152,267	1,152,267	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,496	15,496	6
7	Other Prepaid Expenses	27,074	27,074	7
8	Accounts Receivable (owners or related parties)	97,489	97,489	8
9	Other(specify): <u>See Schedule 17A</u>	332,797	332,797	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,666,356	\$ 1,666,356	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	118,924	124,204	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	129,035	162,272	16
17	Accumulated Depreciation (book methods)	(77,063)	(72,841)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Schedule 17A</u>	171,155	171,155	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 342,051	\$ 384,790	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,008,407	\$ 2,051,146	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 660,675	\$ 660,675	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,462	13,462	28
29	Short-Term Notes Payable	204,999	204,999	29
30	Accrued Salaries Payable	117,694	117,694	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	239,364	239,364	36
37	<u>See Schedule 17A</u>	1,432,111	1,432,111	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,668,305	\$ 2,668,305	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,668,305	\$ 2,668,305	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (659,898)	\$ (617,159)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,008,407	\$ 2,051,146	48

\*(See instructions.)

Coventry Living Center  
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Schedule XV. Balance Sheet

Schedule 17A

	<u>Operating</u>	<u>After Consolidation</u>
<b>Line 9</b>		
Real Estate Tax Escrow	324,764	324,764
Underwithheld Group Insurance	7,383	7,383
Due from Employee Advances	650	650
	<u>332,797</u>	<u>332,797</u>
<b>Line 23</b>		
Capital Improvements Escrow	161,904	161,904
Deposits-Utilities	9,251	9,251
	<u>171,155</u>	<u>171,155</u>
<b>Line 36</b>		
Accrued PTO	79,836	79,836
Due to Medicaid/Medicare Audit	27,143	27,143
General/Property/Liability Ins	10,752	10,752
Worker's Comp Liability	11,101	11,101
Health Savings Account	2,532	2,532
Real Estate Taxes	108,000	108,000
	<u>239,364</u>	<u>239,364</u>
<b>Line 37</b>		
Receivables-Related Party	20	20
Due To Wakefield	262,000	262,000
Due To/From RCOB	(571)	(571)
Due To/From Morris SNF Mgt	1,170,661	1,170,661
	<u>1,432,111</u>	<u>1,432,111</u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (301,497)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>	(172,420)	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (473,917)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(185,981)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (185,981)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (659,898)	<b>24</b> *

\* 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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,822,383	1
2	Discounts and Allowances for all Levels	(1,576,761)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,245,622</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,462,646	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,462,646</b>	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,307	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	483,284	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,879	19
20	Radiology and X-Ray	12,806	20
21	Other Medical Services	287,950	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 819,227</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	14,921	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 14,921</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Schedule 19A</u>	13,158	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 13,158</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,555,574</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	981,374	31
32	Health Care	2,342,089	32
33	General Administration	1,376,849	33
<b>B. Capital Expense</b>			
34	Ownership	904,715	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	913,499	35
36	Provider Participation Fee	223,029	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,741,555</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(185,981)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (185,981)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,480,940	44
45	Private Pay - Net Inpatient Revenue	1,322,360	45
46	Medicare - Net Inpatient Revenue	1,411,012	46
47	Other-(specify) <u>See Schedule 19A</u>	318,122	47
48	Other-(specify) <u>Other Contractual Allowances</u>	(1,286,812)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 3,245,622</b>	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.

Coventry Living Center  
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Schedule 19A

XVII. Income Statement

E. Line 28-Other Income

Amount

Vending Machine Revenue	814
Other Revenue	9,619
Transportation-Private	2,725
	<u>13,158</u>

Line 47 - Other revenue defined by payor source

Managed Care & Retro Revenue	(137,868)
Hospice	455,990
	<u>318,122</u>

Facility Name & ID Number Coventry Living Center

# 0050476

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**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	1,923	\$ 54,930	\$ 28.56	1
2	Assistant Director of Nursing	883	19,116	21.65	2
3	Registered Nurses	7,429	195,533	24.95	3
4	Licensed Practical Nurses	29,667	739,397	21.72	4
5	CNAs & Orderlies	56,354	743,862	9.36	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	5,005	92,777	17.11	8
9	Activity Director				9
10	Activity Assistants	6,630	58,537	8.32	10
11	Social Service Workers	4,118	56,444	13.15	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	17,755	189,787	9.99	15
16	Dishwashers				16
17	Maintenance Workers	5,025	75,231	13.90	17
18	Housekeepers	15,613	145,650	8.66	18
19	Laundry	5,525	54,587	9.12	19
20	Administrator	2,160	84,559	39.15	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	8,048	128,506	15.47	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	1,746	23,608	12.49	31
32	Other Health C: <a href="#">See Sch. 20A</a>	5,104	124,147	23.98	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	172,985	\$ 2,786,671 *	\$ 13.55	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	302	\$ 10,772	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	76	11,300	10(3) 38
39	Pharmacist Consultant	Monthly	9,120	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	68	3,120	11(3) 44
45	Social Service Consultant	Monthly	748	12(3) 45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	446	\$ 54,968	49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	611	12,225	10(3) 52
53	TOTAL (lines 50 - 52)	611	\$ 12,225	53

Coventry Living Center  
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Schedule 20A

Ln 32 - Other Health Care

Name	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salary</u>	<u>AHW</u>
MDS Coordinator	4,434	4,464	\$ 118,557	\$ 26.56
Staffing Coordinator	400	400	\$ 4,274	\$ 10.68
Central Supply	270	313	\$ 1,317	\$ 4.21
Total	5,104	5,177	\$ 124,147	23.98



Facility Name & ID Number Coventry Living Center

# 0050476

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Emily Dykstra	Administrator	0	\$ 84,559	Workers' Compensation Insurance	\$ 129,608	IDPH License Fee	\$	
				Unemployment Compensation Insurance	115,594	Advertising: Employee Recruitment	10,250	
				FICA Taxes	213,180	Health Care Worker Background Check		
				Employee Health Insurance	43,560	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	307 3,686	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Fees	5,067	
				Other Employee Benefits	(17,197)	Miscellaneous Dues & Subscriptions	809	
TOTAL (agree to Schedule V, line 17, col. 1)						Allocated from Home Office	722	
(List each licensed administrator separately.)			\$ 84,559			Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 20,534	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)				
Management Fees (Eliminated in col. 7)			\$ 328,980					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 328,980	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description	Line #	Amount		
C. Professional Services							G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount					Description	Amount
Brian LaLonde, CPA	Accounting	\$ 2,650		N/A			Out-of-State Travel	\$
WW Healthcare Consultants	Accounting	83						
Nebo	Data processing	240					In-State Travel	
ADP, Inc	Data processing	32,538						
MDI Achieve Inc-Quickcare	Payroll Processing	9,499					Seminar Expense	1,365
COMS	Data Processing	19,215						
Ogletree, Deakins	Legal	35,272					Management Company Allocation	10,970
McGladrey LLP	Accounting	5,355					Entertainment Expense	( )
Sch 21C	Other professional service	3,398					(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 108,250				TOTAL	\$ 12,335

\* Attach copy of IMRF notifications

\*\*See instructions.

Coventry Living Center  
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Schedule 21A

C. Professional Fees

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
OSF Medical Group	Other professional services	62
Rockford Orthopedic	Other professional services	833
Northern Illinois Rehab	Other professional services	1,041
CGH Clinic	Other professional services	1,447
Cardiovascular Medicine	Other professional services	15
	Total to P21C	<u>3,398</u>

PG 21 Detail - Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Brian LaLonde, CPA	Accounting	2,650
WW Health Care Consultants LLC	Accounting	83
Nebo	DP	240
MDI Achieve	Data Processing	9,499
COMS Interactive, LLC	Data Processing	19,215
ADP, Inc	Payroll Processing	32,538
Ogletree Deakins, Polsinelli Shughart, Bailey & Harneck	Legal	35,272
McGladrey LLP	Accounting	5,355
Other Professional Services	Other Professional Services	<u>3,398</u>
Line #19 Column 3 Total		108,250
Plus: Allocated from Management Company	Accounting	4,535
Plus: Allocated from Management Company	Legal	16,615
Line #19 Column 8 Total		<u>129,400</u>

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	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Coventry Living Center# 0050476Report Period Beginning: 01/01/2013 Ending: 12/31/2013**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,738 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. \$ 223,029  
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. \$ 1,307
- (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? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.