FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0050476

Facility Name: Coventry Living Center

Address: 612 West St Marys St (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

Telephone Number: (828) 324-8898 **Fax #** Faxes not accepted

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 01/01/2015 to 12/31/2015 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) RSM US 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: 01/01/2015 Ending: 12/31/2015

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	130	Skilled (SNF)	130	47,450	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	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	10,616	11,622	9,715	31,953	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,616	11,622	9,715	31,953	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.34%

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 130 and days of care provided 6,237

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: 12/31/15 Fiscal Year: 12/31/15

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

Facility Name & ID Number Coventry Living Center # 0050476 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

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	180,898	48,068	9,975	238,941		238,941		238,941			1
2	Food Purchase		199,541		199,541		199,541	(655)	198,886			2
3	Housekeeping	121,514	18,046		139,560		139,560		139,560			3
4	Laundry	46,544	21,852		68,395		68,395		68,395			4
5	Heat and Other Utilities			122,007	122,007		122,007	2,872	124,879			5
6	Maintenance	68,396	23,312	63,516	155,223		155,223	(662)	154,561			6
7	Other (specify):*											7
8	**TOTAL General Services**	417,352	310,818	195,497	923,668		923,668	1,555	925,223			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,830,619	176,409	23,258	2,030,286		2,030,286		2,030,286			10
10a	Therapy											10a
11	Activities	54,710	3,818	8,169	66,697		66,697		66,697			11
12	Social Services	74,918		2,860	77,778		77,778		77,778			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,960,247	180,227	49,287	2,189,761		2,189,761		2,189,761			16
	C. General Administration											
17	Administrative	84,909		351,541	436,450		436,450	(351,541)	84,909			17
18	Directors Fees											18
19	Professional Services			63,372	63,372		63,372	3,419	66,791			19
20	Dues, Fees, Subscriptions & Promotions			14,905	14,905		14,905	85	14,990			20
21	Clerical & General Office Expenses	88,638	16,988	39,404	145,030		145,030	224,523	369,553			21
22	Employee Benefits & Payroll Taxes			735,081	735,081		735,081		735,081			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,249	1,249		1,249	6,377	7,626			24
25	Other Admin. Staff Transportation			31,186	31,186		31,186		31,186			25
26	Insurance-Prop.Liab.Malpractice			152,927	152,927		152,927	1,426	154,353			26
27	Other (specify):* HO Alloc Benefits							31,620	31,620			27
28	**TOTAL General Administration**	173,547	16,988	1,389,666	1,580,201		1,580,201	(84,091)	1,496,110			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,551,147	508,033	1,634,451	4,693,631		4,693,631	(82,536)	4,611,095			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:** 01/01/2015 **Ending:** 12/31/2015

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			51,705	51,705		51,705	34,994	86,699			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3	3		3	34,404	34,407			32
33	Real Estate Taxes			110,692	110,692		110,692		110,692			33
34	Rent-Facility & Grounds			810,608	810,608		810,608		810,608			34
35	Rent-Equipment & Vehicles			2,815	2,815		2,815	5,303	8,118			35
36	Other (specify):*											36
37	**TOTAL Ownership**			975,823	975,823		975,823	74,701	1,050,524			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		198,549	626,790	825,339		825,339		825,339			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			225,288	225,288		225,288		225,288			42
43	Other (specify):* **Non-Allowable Cos**			198,975	198,975		198,975	(198,975)	(0)			43
44	**TOTAL Special Cost Centers**		198,549	1,051,053	1,249,601		1,249,601	(198,975)	1,050,626			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,551,147	706,582	3,661,326	6,919,055		6,919,055	(206,810)	6,712,245			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: 01/01/2015 Ending: 12/31/2015

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	(655)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,312)	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	29,465	30		9
10	Interest and Other Investment Income	(1,320)	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	(2,427)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,586)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(145,000)	43		24
25	Fund Raising, Advertising and Promotional	(15,642)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(45,981)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (191,458)		$	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)	(15,352)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (15,352)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (206,810)		37

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

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

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

Coventry Living Center

ID# 0050476

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Radiology-Other Contracted Services	$ (11,857)	43	1
2	Lab-Contract Services	(16,737)	43	2
3	Non Allowable HO Expenses	(2,623)	43	3
4	Offset Other Income Against A&G - Other	(11,312)	21	4
5	To reclass R&M to Building Improvements	(2,595)	6	5
6	Non Allowable dues	(857)	20	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				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**	(45,981)		49

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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
		Regency Care of Morris	Morris, IL	Regency Holdings LL(	Hickory, NC	Holding Co.
		Regency Care of Arlington, LLC	Virginia	SCK Assurance LLC	Hickory, NC	Insurance Co.
				WW Healthcare Const	Hickory, NC	Mgmt 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 [X] 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		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ * 0	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: 01/01/2015 Ending: 12/31/2015

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	5	Utilities	$	WW Healthcare Consultants, LLC	100.00%	$ 2,872	$ 2,872	15
16	V	6	Maintenance & Repair - Other		WW Healthcare Consultants, LLC	100.00%	1,933	1,933	16
17	V	17	Management Fees	351,541	WW Healthcare Consultants, LLC	100.00%		(351,541)	17
18	V	19	Professional Services		WW Healthcare Consultants, LLC	100.00%	6,005	6,005	18
19	V	20	Licenses		WW Healthcare Consultants, LLC	100.00%	942	942	19
20	V	21	Salaries / Wages		WW Healthcare Consultants, LLC	100.00%	194,123	194,123	20
21	V	21	Clerical/General-Other		WW Healthcare Consultants, LLC	100.00%	13,808	13,808	21
22	V	21	Office/Other Supplies		WW Healthcare Consultants, LLC	100.00%	27,904	27,904	22
23	V	24	Travel		WW Healthcare Consultants, LLC	100.00%	6,377	6,377	23
24	V	26	Insurance		WW Healthcare Consultants, LLC	100.00%	1,426	1,426	24
25	V	27	Employee Benefits		WW Healthcare Consultants, LLC	100.00%	31,620	31,620	25
26	V	30	Depreciation		WW Healthcare Consultants, LLC	100.00%	5,529	5,529	26
27	V	32	Interest		WW Healthcare Consultants, LLC	100.00%	35,724	35,724	27
28	V	35	Equipment Rent		WW Healthcare Consultants, LLC	100.00%	5,303	5,303	28
29	V	43	Other Costs		WW Healthcare Consultants, LLC	100.00%	2,623	2,623	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			$ 351,541			$ 336,189	$ * (15,352)	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: 01/01/2015 Ending: 12/31/2015

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	22	Employee Beneifts - Work. Comp	$ 60,874	SCK Assurance LLC		$ 60,874	$	15
16	V	26	Insurance - Gen & Prof Liability	60,682	SCK Assurance LLC		60,682		16
17	V	26	Insurance - RAC Audit	17,554	SCK Assurance LLC		17,554		17
18	V	26	Insurance - Health Insurance	39,331	SCK Assurance LLC		39,331		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			$ 178,441			$ 178,441	$ * 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: 01/01/2015 Ending: 12/31/2015

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											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: 01/01/2015 Ending: 2/31/2015

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) 324-8898
Fax Number: (

	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	5	Utilities	Patient Days	242,035	7	$ 21,757	$	31,953	$ 2,872	1
2	6	Maintenance & Repair - Other	Patient Days	242,035	7	14,640		31,953	1,933	2
3	19	Professional Services	Patient Days	242,035	7	45,487		31,953	6,005	3
4	20	Licenses	Patient Days	242,035	7	7,134		31,953	942	4
5	21	Salaries / Wages	Patient Days	242,035	7	1,470,426	1,470,426	31,953	194,123	5
6	21	Clerical/General-Other	Patient Days	242,035	7	104,588		31,953	13,808	6
7	21	Office/Other Supplies	Patient Days	242,035	7	211,364		31,953	27,904	7
8	24	Travel	Patient Days	242,035	7	48,303		31,953	6,377	8
9	26	Insurance	Patient Days	242,035	7	10,798		31,953	1,426	9
10	27	Employee Benefits	Patient Days	242,035	7	239,514		31,953	31,620	10
11	30	Depreciation	Patient Days	242,035	7	41,884		31,953	5,529	11
12	32	Interest	Patient Days	242,035	7	270,602		31,953	35,724	12
13	35	Equipment Rent	Patient Days	242,035	7	40,168		31,953	5,303	13
14	43	Other Costs	Patient Days	242,035	7	19,865		31,953	2,623	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,546,530	$ 1,470,426		$ 336,189	25

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 01/01/2015 Ending: 2/31/2015

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) 324-8898
Fax Number: (

	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	22	Employee Benefits-Work. Comp	Direct Cost			$	$		$ 60,874	1
2	26	Insurance-Gener & Prof Liability	Direct Cost						60,682	2
3	26	Insurance-RAC Audit	Direct Cost						17,554	3
4	26	Insurance - Health Insurance	Direct Cost						39,331	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					$	$		$ 178,441	25

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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				N/A			$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10								Miscellaneous Int Exp			3	10
11								Offset Interest Income			(1,320)	11
12												12
13								Allocated from Home Office			35,724	13
14	TOTAL Non-Facility Related						$	$			$ 34,407	14
15	TOTALS (line 9+line14)						$	$			$ 34,407	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:** 01/01/2015 **Ending:** 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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.)	2014	$ 263,554	2
3. Under or (over) accrual (line 2 minus line 1).		$ 263,554	3
4. Real Estate Tax accrual used for 2015 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
	Cottage Taxes - Non Allowable	(152,862)	
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. **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.		$ 110,692	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	279,562	8
	2011	255,575	9
	2012	252,653	10
	2013	258,255	11
	2014	263,554	12

Facility does not accrue real estate taxes.

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 263,269.52	$ 110,408.39
2.	11-16-151-002	Long-Term Care Property	$ 283.80	$ 283.80
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 263,553.32	$ 110,692.19

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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	2,119	9
10	Plumbing			2010	7,897	790	10	790	(0)	4,410	10
11	Mixing Valves			2009	3,305		15	220	220	1,357	11
12	Heater Repair			2010	3,450		5	345	345	3,450	12
13	Generator Repair			2010	4,331		5	434	434	4,331	13
14	Generator Repair			2010	2,981		5	299	299	2,981	14
15	TD Kurtz glass new door			2011	9,397	470	20	470		2,115	15
16	TD Kurtz glass new door			2011	9,297	465	20	464	(1)	2,088	16
17	Repairs-Carpet Service			2011	2,729		20	136	136	612	17
18	Repairs-Site inspection			2011	8,446		20	422	422	1,899	18
19	Repairs-Roofing power			2011	2,910		20	146	146	657	19
20											20
21	New Heat Exchanger			2013	8,700	870	10	870		2,175	21
22	Replace Existing Water Soure Heat Pumps			2013	48,785	4,878	10	4,879	1	12,197	22
23	HVAC			2013	2,500	208	10	250	42	625	23
24	Interior Design Fee			2013	4,400	367	10	440	73	1,100	24
25											25
26	New Phones and Phone System-Entire Facility			2014	17,468	1,575	10	1,747	172	2,620	26
27	New Roof			2014	174,900	1,458	10	17,490	16,032	26,235	27
28	New AO Smith 100 Gallon Hot Water Heater			2014	3,996		10	400	400	600	28
29	Install new outside condensing unit			2014	3,800		10	380	380	570	29
30	Repair for 2 Generators			2014	2,533		10	253	253	380	30
31											31
32	Remove Condensor from 400 wing and install new			2015	2,595		10	130	130	130	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: 01/01/2015 Ending: 12/31/2015

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	Remove Water Based Heat Pumps & Install Forced Air Units	2010	250,805		10	25,081	25,081	137,946	39
40	and Additional Duct Work for Air Flow-Half of Facility								40
41	Renovate Hallway and Replace Nurse Station with Private	2010	53,123		10	5,312	5,312	29,216	41
42	Rooms - Villa Hall								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)		$ 633,424	$ 11,419		$ 61,297	$ 49,878	$ 239,813	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: 01/01/2015 Ending: 12/31/2015

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	$ 162,272	$ 34,320	$ 16,227	$ (18,093)	10	$ 85,260	71
72	Current Year Purchases	23,206	4,641	2,321	(2,321)	5	2,321	72
73	Fully Depreciated Assets							73
74	Management Company Allocation			5,529	5,529			74
75	TOTALS	$ 185,478	$ 38,961	$ 24,077	$ (14,884)		$ 87,581	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	Facility Use	Chevy Snow Truck 1999	2015	$ 4,800	$ 480	$ 480	$	5	$ 480	76
77	Facility Use	Chevy Van 2002	2015	8,449	845	845	(0)	5	845	77
78										78
79										79
80	TOTALS			$ 13,249	$ 1,325	$ 1,325	$ (0)		$ 1,325	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)	$ 832,151	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,705	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,699	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 34,993	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 328,720	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	CIP	$ 10,000	92
93			93
94			94
95		$ 10,000	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: 01/01/2015 Ending: 12/31/2015

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	$ 810,608			3
4	Additions							4
5								5
6								6
7	TOTAL		130		$ 810,608 **			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.	/2016	$ 835,000
13.	/2017	$ 860,000
14.	/2018	$ 885,000

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: $ 8,118 Description: Dish Machine $2,700; Other Rent/Lease Expense $115; HO Allocation $5,303
    (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.

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	5,001	$ 287,791	$	5,001	$ 287,791	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		636	36,074		636	36,074	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(2),(3)	hrs		7,168	302,925	307	7,168	303,232	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				198,242		198,242	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	12,805	$ 626,790	$ 198,549	12,805	$ 825,339	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 # 0050476 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (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	$ 63,577	$ 63,577	1
2	Cash-Patient Deposits	25,701	25,701	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 122,044)	1,401,838	1,401,838	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,444	20,444	6
7	Other Prepaid Expenses	21,379	21,379	7
8	Accounts Receivable (owners or related parties)	956,637	956,637	8
9	Other(specify): See Schedule 17A	344,418	344,418	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,833,994	$ 2,833,994	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	311,292	633,424	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	165,490	198,727	16
17	Accumulated Depreciation (book methods)	(157,721)	(328,720)	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 CIP	10,000	10,000	22
23	Other(specify): See Schedule 17A	84,485	84,485	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 413,547	$ 597,917	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,247,541	$ 3,431,911	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 767,128	$ 767,128	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,701	25,701	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,475	115,475	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	277,345	277,345	36
37	See Schedule 17A	2,595,858	2,595,858	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,781,508	$ 3,781,508	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)**	$ 3,781,508	$ 3,781,508	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (533,967)	$ (349,597)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,247,541	$ 3,431,911	48

***(See instructions.)**

Facility Name: **Coventry Living Center**
IDPH License ID Number: **0050476**
Fiscal Year End: **12/31/2015**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
RC Benefits Cash Account	8,168	8,168
Real Estate Tax Escrow	325,998	325,998
W/H Group Insurance	6,854	6,854
Employee Advances	1,541	1,541
Due to/from Employee-Health In	352	352
Due to/from SCK	1,505	1,505
Total - Line 9	**344,418**	**344,418**

XV. Balance Sheet
Line 23 Long-Term Assets Other (specify):

Description	Operating	After Consolidation
Capital Improvements Escrow	75,234	75,234
Deposits-Utilities	9,251	9,251
Total - Line 23	**84,485**	**84,485**

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Suspense	30,688	30,688
Prepaid Workers Comp	(115)	(115)
Accrued PTO	59,880	59,880
Health Savings Account	60	60
RC Benefits Liability	9,041	9,041

Real Estate Taxes	110,000	110,000
General/Property/Liability Insurance	10,752	10,752
Reserve for Mcaid/Mcare Audit	43,100	43,100
Retro Revenue Reserve	13,939	13,939
Total - Line 36	**277,345**	**277,345**

XV. Balance Sheet

Line 37 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due to Medicaid	87,592	87,592
Due to/from WWHCC	2,508,786	2,508,786
Due to/from IDA	(520)	(520)
Total - Line 37	**2,595,858**	**2,595,858**

Facility Name & ID Number Coventry Living Center **#** 0050476 **Report Period Beginning:** 01/01/2015 **Ending:** 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (645,738)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (645,738)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	111,773	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **Rounding**	(1)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 111,772	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)**	$ (533,967)	24	*

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

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	$ 5,482,325	1
2	Discounts and Allowances for all Levels	(2,982,341)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,499,984	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	4,135,376	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 4,135,376	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	46	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	212,247	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	13,056	19
20	Radiology and X-Ray	5,236	20
21	Other Medical Services	151,642	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 382,227	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,320	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,320	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	11,921	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,921	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,030,828	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	923,668	31
32	Health Care	2,189,761	32
33	General Administration	1,580,201	33
	B. Capital Expense		
34	Ownership	975,823	34
	C. Ancillary Expense		
35	Special Cost Centers	1,024,313	35
36	Provider Participation Fee	225,288	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,919,055	40
41	**Income before Income Taxes (line 30 minus line 40)****	111,773	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 111,773	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,479,785	44
45	Private Pay - Net Inpatient Revenue	1,841,325	45
46	Medicare - Net Inpatient Revenue	(992,613)	46
47	Other-(specify) Managed Care & Hospice	363,218	47
48	Other-(specify) Other Patient Revenue	(191,731)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,499,984	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

Facility Name: **Coventry Living Center**
IDPH License ID Number: **0050476**
Fiscal Year End: **12/31/2015**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
Vending Machine Revenue	609
Other Revenue	11,312
Total - Line 28	**11,921**

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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	2,160	2,391	$ 64,684	$ 27.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,853	11,615	301,369	25.95	3
4	Licensed Practical Nurses	23,737	25,526	586,042	22.96	4
5	CNAs & Orderlies	68,530	74,231	682,328	9.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,864	4,138	78,650	19.01	8
9	Activity Director					9
10	Activity Assistants	5,299	5,729	54,710	9.55	10
11	Social Service Workers	4,714	5,203	74,918	14.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,512	16,630	180,898	10.88	15
16	Dishwashers					16
17	Maintenance Workers	3,873	4,204	68,396	16.27	17
18	Housekeepers	13,755	14,733	121,514	8.25	18
19	Laundry	4,835	5,318	46,544	8.75	19
20	Administrator	1,880	2,080	84,909	40.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,401	5,832	88,638	15.20	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	1,986	2,127	32,549	15.30	31
32	Other Health C: MDS Coordinator	3,833	4,302	84,998	19.76	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	170,230	184,059	$ 2,551,147 *	$ 13.86	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	198	$ 9,975	1(3)	35
36	Medical Director	Monthly	15,000	9(3)	36
37	Medical Records Consultant	Quarterly	1,940	10(3)	37
38	Nurse Consultant	46	5,900	10(3)	38
39	Pharmacist Consultant	Monthly	11,033	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	70	1,690	11(3)	44
45	Social Service Consultant	119	2,860	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	433	$ 48,398		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	110	$ 4,385	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	110	$ 4,385		53

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Emily Dykstra	Administrator	0	$ 84,909
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 84,909

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in col. 7)	$ 351,541
TOTAL (agree to Schedule V, line 17, col. 3)	$ 351,541
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Monthly Accruals	Accounting	$ 6,855
Wescom Solutions	Data Processing	19,854
Matrixcare	Data Processing	(1,583)
Nebo Systems	Data Processing	220
Monthly Accruals	Bookkeeping & Accounting	6,000
Paylocity	Payroll Processing	19,997
O'Hagan Spencer	Legal	4,388
Polsinelli Shughart	Legal	4,204
WW Healthcare Co.	Legal	89
OSF Medical Group	Other Professional Fees	231
See Attached SCH 21C	Various	3,117
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 63,372

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 120,208
Unemployment Compensation Insurance	122,006
FICA Taxes	195,163
Employee Health Insurance	79,209
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	218,494
TOTAL (agree to Schedule V, line 22, col.8)	$ 735,081

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	$
Advertising: Employee Recruitment	702
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 292	3,502
Miscellaneous Licenses & Fees	6,521
Miscellaneous Dues & Subscriptions	4,180
Non allowable Dues	(857)
Allocated from Home Office	942
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,990

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,249
Allocated from Home Office	6,377
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,626

**See instructions.

Facility Name: **Coventry Living Center**
IDPH License ID Number: **0050476**
Fiscal Year End: **12/31/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
KSB	Other professional services	281
Rockford Orthopedic	Other professional services	129
CGH Clinic	Other professional services	1,136
Northern Illinois Retina	Other professional services	1,571

Total (agree to Schedule V, line 19, column 3)	3,117
Allocated from Management Company Legal Fees	3,361
Allocated from Management Company Professional Services	2,644
Less: Non-Allowable Legal Fees	(2,586)
Total (agree to Schedule V, line 19, column 8)	66,791

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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: 01/01/2015 Ending: 12/31/2015

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? **Yes**
If YES, give association name and amount. **IHCA - $2275**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **18,184** 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. $ **225,288**
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. $ **46**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.