

Facility Name & ID Number Coventry Village

0047761 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	124	Skilled (SNF)	124	45,260	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	6	Sheltered Care (SC)	6	2,190	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,269	356	5,480	11,105	8
9	SNF/PED					9
10	ICF	8,372	6,660	922	15,954	10
11	ICF/DD					11
12	SC		2,068	122	2,190	12
13	DD 16 OR LESS					13
14	TOTALS	13,641	9,084	6,524	29,249	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.64%

D. How many bed-hold days during this year were paid by the Department? None (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)
N/A

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 03/21/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/21/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 48 and days of care provided 4,454

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Coventry Village # 0047761 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	148,108	15,718	6,790	170,616		170,616		170,616		1
2	Food Purchase		138,969		138,969		138,969	(6,422)	132,547		2
3	Housekeeping	81,471	27,401		108,872		108,872		108,872		3
4	Laundry	54,732	20,798		75,530		75,530		75,530		4
5	Heat and Other Utilities			172,326	172,326		172,326	632	172,958		5
6	Maintenance	60,982	8,547	54,896	124,425		124,425	24	124,449		6
7	Other (specify):*										7
8	TOTAL General Services	345,293	211,433	234,012	790,738		790,738	(5,766)	784,972		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,244,334	73,106	5,320	1,322,760		1,322,760	11,909	1,334,669		10
10a	Therapy			352,196	352,196		352,196		352,196		10a
11	Activities	52,895	2,273	717	55,885		55,885		55,885		11
12	Social Services	32,672		1,597	34,269		34,269		34,269		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* EE Bene. - Mgmt. Co							1,751	1,751		15
16	TOTAL Health Care and Programs	1,329,901	75,379	365,830	1,771,110		1,771,110	13,660	1,784,770		16
	C. General Administration										
17	Administrative	82,769		85,433	168,202		168,202	76,684	244,886		17
18	Directors Fees										18
19	Professional Services			177,321	177,321		177,321	(121,433)	55,888		19
20	Dues, Fees, Subscriptions & Promotions			14,202	14,202		14,202	(565)	13,637		20
21	Clerical & General Office Expenses	51,361	12,869	37,430	101,660		101,660	(54,932)	46,728		21
22	Employee Benefits & Payroll Taxes			431,387	431,387		431,387		431,387		22
23	Inservice Training & Education							553	553		23
24	Travel and Seminar			984	984		984	8,977	9,961		24
25	Other Admin. Staff Transportation			36,893	36,893		36,893	1,095	37,988		25
26	Insurance-Prop.Liab.Malpractice			98,517	98,517		98,517	1,269	99,786		26
27	Other (specify):* EE Bene. - Mgmt. Co							11,910	11,910		27
28	TOTAL General Administration	134,130	12,869	882,167	1,029,166		1,029,166	(76,442)	952,724		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,809,324	299,681	1,482,009	3,591,014		3,591,014	(68,548)	3,522,466		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Coventry Village

#0047761

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
	D. Ownership											
30	Depreciation			3,589	3,589		3,589	20,492	24,081			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,273	73,273		73,273	(46)	73,227			32
33	Real Estate Taxes			63,150	63,150		63,150		63,150			33
34	Rent-Facility & Grounds			781,554	781,554		781,554	6,430	787,984			34
35	Rent-Equipment & Vehicles			55,087	55,087		55,087	1,794	56,881			35
36	Other (specify):*											36
37	TOTAL Ownership			976,653	976,653		976,653	28,670	1,005,323			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,770		124,770		124,770		124,770			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,890	67,890		67,890		67,890			42
43	Other (specify):* Non-allowable Cos	16,620	6,556	61,233	84,409		84,409	(84,409)				43
44	TOTAL Special Cost Centers	16,620	131,326	129,123	277,069		277,069	(84,409)	192,660			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,825,944	431,007	2,587,785	4,844,736		4,844,736	(124,287)	4,720,449			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coventry Village

0047761

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,422)	2		4
5	Telephone, TV & Radio in Resident Rooms	(910)	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	(2,276)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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				24
25	Fund Raising, Advertising and Promotional	(15,266)	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 Pg. 5A	(48,817)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (73,691)		\$	30

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	
		Amount	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)	(50,596)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (50,596)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (124,287)		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	
		Yes	No	Amount	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	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Coventry Village

ID# 0047761

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow non-allowable Marketing salaries	\$ (16,620)	43	1
2	Disallow non-allowable Marketing supplies	(6,556)	43	2
3	Disallow non-allowable Marketing consultant	(2,160)	43	3
4	Disallow non-allowable Penalties	(511)	43	4
5	Offset interest income against interest expense	(46)	32	5
6	Disallow Medicare Laboratory	(41,371)	43	6
7	Disallow Medicare X-Ray	(1,015)	43	7
8	Disallow IC-LTC Non-Allow lobbying Expense	(1,703)	20	8
9	Add-on Lessor Building Improvements	21,165	30	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(48,817)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Coventry Village# 0047761

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,422)	0	0	0	0	0	0	0	0	0	0	(6,422)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	632	0	0	0	0	0	0	0	0	632	5
6	Maintenance	0	0	24	0	0	0	0	0	0	0	0	24	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,422)	0	656	0	(5,766)	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	11,909	0	0	0	0	0	0	0	0	11,909	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	1,751	0	0	0	0	0	0	0	0	1,751	15
16	TOTAL Health Care and Programs	0	0	13,660	0	13,660	16							
	C. General Administration													
17	Administrative	0	0	(8,749)	0	0	0	0	0	0	0	0	(8,749)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(121,433)	0	0	0	0	0	0	0	0	(121,433)	19
20	Fees, Subscriptions & Promotions	(1,703)	0	1,138	0	0	0	0	0	0	0	0	(565)	20
21	Clerical & General Office Expenses	0	0	30,501	0	0	0	0	0	0	0	0	30,501	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	553	0	0	0	0	0	0	0	0	553	23
24	Travel and Seminar	0	0	8,977	0	0	0	0	0	0	0	0	8,977	24
25	Other Admin. Staff Transportation	0	0	1,095	0	0	0	0	0	0	0	0	1,095	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,269	0	0	0	0	0	0	0	0	1,269	26
27	Other (specify):*	0	0	11,910	0	0	0	0	0	0	0	0	11,910	27
28	TOTAL General Administration	(1,703)	0	(74,739)	0	(76,442)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,125)	0	(60,423)	0	(68,548)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Coventry Village# 0047761

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	18,889	0	1,603	0	0	0	0	0	0	0	0	20,492	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(46)	0	0	0	0	0	0	0	0	0	0	(46)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,430	0	0	0	0	0	0	0	0	6,430	34
35	Rent-Equipment & Vehicles	0	0	1,794	0	0	0	0	0	0	0	0	1,794	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	18,843	0	9,827	0	28,670	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(84,409)	0	0	0	0	0	0	0	0	0	0	(84,409)	43
44	TOTAL Special Cost Centers	(84,409)	0	0	0	0	0	0	0	0	0	0	(84,409)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(73,691)	0	(50,596)	0	(124,287)	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Suzanne Koenig	100%	See Attached Sch 6A		See Attached Sch 6B		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	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		\$			\$	\$ *	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	5 Utilities	\$	SAK Management Services, LLC	100.00%	\$ 632	\$	632	15
16	V	6 Maintenance		SAK Management Services, LLC	100.00%	24		24	16
17	V	10 Nursing - Salaries		SAK Management Services, LLC	100.00%	11,909		11,909	17
18	V	17 Administrative		SAK Management Services, LLC	100.00%	56,317		56,317	18
19	V	17 Administrative	85,433	SAK Management Services, LLC	100.00%	20,367		(65,066)	19
20	V	19 Professional Services	128,149	SAK Management Services, LLC	100.00%	6,716		(121,433)	20
21	V	20 Dues, Fees & Subscriptions		SAK Management Services, LLC	100.00%	1,138		1,138	21
22	V	21 Clerical & General		SAK Management Services, LLC	100.00%	5,840		5,840	22
23	V	21 Clerical & General - Salaries		SAK Management Services, LLC	100.00%	24,661		24,661	23
24	V	23 Inservice Training & Education		SAK Management Services, LLC	100.00%	553		553	24
25	V	24 Travel & Seminar		SAK Management Services, LLC	100.00%	5,731		5,731	25
26	V	25 Other Admin. Staff Transportation		SAK Management Services, LLC	100.00%	1,095		1,095	26
27	V	26 Insurance - Property & Liability		SAK Management Services, LLC	100.00%	1,269		1,269	27
28	V	27 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC	100.00%	11,910		11,910	28
29	V	30 Depreciation		SAK Management Services, LLC	100.00%	1,603		1,603	29
30	V	34 Rent - Facility & Grounds		SAK Management Services, LLC	100.00%	6,430		6,430	30
31	V	35 Rent - Equipment & Vehicles		SAK Management Services, LLC	100.00%	1,712		1,712	31
32	V								32
33	V	15 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC	100.00%	1,751		1,751	33
34	V	24 Travel & Seminar		SAK Management Services, LLC	100.00%	3,246		3,246	34
35	V	35 Rent - Equipment & Vehicles		SAK Management Services, LLC	100.00%	82		82	35
36	V								36
37	V								37
38	V								38
39	Total		\$ 213,582			\$ 162,986	\$ *	(50,596)	39

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

Facility Name & ID Number

Coventry Village

0047761

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	Suzanne Koenig	Owner	Administrative	100.00	See Attached	7	11.60	Comp	\$ 20,367	17(7)	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,367		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coventry Village

0047761

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

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 SAK Management Services, LLC
 Street Address 4055 W. Peterson, Suite 101
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 202-0000
 Fax Number (773) 267-0111

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	5	Utilities	SAK Managment Fees	1,890,235	8	\$ 5,596	\$ 213,582	\$ 632	1
2	6	Maintenance	SAK Managment Fees	1,890,235	8	211	213,582	24	2
3	10	Nursing	SAK Managment Fees	1,890,235	8	105,396	213,582	11,909	3
4	17	Administrative	SAK Managment Fees	1,890,235	8	498,418	213,582	56,317	4
5	17	Administrative	SAK Managment Fees	1,890,235	8	180,250	213,582	20,367	5
6	19	Professional Services	SAK Managment Fees	1,890,235	8	59,442	213,582	6,716	6
7	20	Dues, Fees & Subscriptions	SAK Managment Fees	1,890,235	8	10,072	213,582	1,138	7
8	21	Clerical & General	SAK Managment Fees	1,890,235	8	51,688	213,582	5,840	8
9	21	Clerical & General - Salaries	SAK Managment Fees	1,890,235	8	218,250	213,582	24,661	9
10	23	Inservice Training & Education	SAK Managment Fees	1,890,235	8	4,891	213,582	553	10
11	24	Travel & Seminar	SAK Managment Fees	1,890,235	8	50,720	213,582	5,731	11
12	25	Other Admin. Staff Transportation	SAK Managment Fees	1,890,235	8	9,694	213,582	1,095	12
13	26	Insurance - Prop & Liability	SAK Managment Fees	1,890,235	8	11,235	213,582	1,269	13
14	27	Employee Benefits - Mgmt. Co.	SAK Managment Fees	1,890,235	8	120,902	213,582	13,661	14
15	30	Depreciation	SAK Managment Fees	1,890,235	8	14,188	213,582	1,603	15
16	34	Rent - Facility & Grounds	SAK Managment Fees	1,890,235	8	56,907	213,582	6,430	16
17	35	Rent - Equipment & Vehicles	SAK Managment Fees	1,890,235	8	15,154	213,582	1,712	17
18									18
19									19
20	24	Travel & Seminar	Direct Cost			18,959		3,246	20
21	35	Rent - Equipment & Vehicles	Direct Cost			966		82	21
22									22
23									23
24									24
25	TOTALS				\$ 1,432,939	\$ 822,064		\$ 162,986	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Coventry Village

0047761

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6	Capital Source		X	Line of Credit	Varied	4/2006		610,877	3/2009	Prime+1	71,739	6						
7	CBC Holdings, Inc.		X	Start up Loan	\$5,926.00	3/2006			2/2007	Prime+4	440	7						
8	National Government Services		X	Cost Report Settlement	\$3,465.00	9/2007		99,951	8/2008	0.1263	1,094	8						
9	TOTAL Facility Related				\$9,391.00		\$	\$ 710,828			\$ 73,273	9						
	B. Non-Facility Related*																	
10								Offset interest income			(46)	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ (46)	14						
15	TOTALS (line 9+line14)						\$	\$ 710,828			\$ 73,227	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Coventry Village COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0047761

CONTACT PERSON REGARDING THIS REPORT Suzanne Koenig

TELEPHONE (773) 202-0000 FAX #: (773) 267-0111

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coventry Village

0047761

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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 in 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: N/A
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		200 Hall & 400 Hall Commodes		2007	6,686	955	10	334	(621)	334	9
10		Replace Fire Sprinkler Heads, smoke detector & strobe		2007	4,457	637	10	223	(414)	223	10
11		Roofing - Main Building		2007	10,000	1,429	20	250	(1,179)	250	11
12											12
13		Lessor Additions:									13
14		10 New Heater Pumps		2006	67,093		10	10,064	10,064	10,064	14
15		Windows & Doors Installed		2006	4,934		7	1,057	1,057	1,057	15
16		HVAC Unit Installed & Tested		2007	141,149		10	7,057	7,057	7,057	16
17		100 Hall Fire Systems Balanced to meet code		2007	7,887		10	394	394	394	17
18		2 Fire Rooms Added on - Walls, Ceiling Tiles, Caulking, etc		2007	27,447		10	1,372	1,372	1,372	18
19		Install 102 and Fix 108 Fire Dampers		2007	14,265		10	713	713	713	19
20		Attach and Install New Gas Main		2007	3,800		7	271	271	271	20
21		Refurbish Resident Rooms - Tile, Paint, Ceiling Tile, etc		2007	3,285		7	235	235	235	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)	\$ 291,003	\$ 3,021		\$ 21,972	\$ 18,951	\$ 21,972	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Coventry Village

0047761

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 5,058	\$ 568	\$ 506	\$ (62)	10	\$ 1,684	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from SAK Management			1,603	1,603			74
75	TOTALS	\$ 5,058	\$ 568	\$ 2,109	\$ 1,541		\$ 1,684	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 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)	\$ 296,061	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,589	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,081	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,492	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 23,656	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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>2. <u>CLASSROOM PORTION:</u></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>3. <u>CLINICAL PORTION:</u></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	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.
- SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,571	\$ 154,287	\$	2,571	\$ 154,287	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		217	13,044		217	13,044	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,081	184,865		3,081	184,865	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				124,770		124,770	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	5,869	\$ 352,196	\$ 124,770	5,869	\$ 476,966	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coventry Village

0047761

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 36,501	\$ 36,501	1
2	Cash-Patient Deposits	16,700	16,700	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 106,154)	864,851	864,851	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	43,104	43,104	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Payroll Advance	300	300	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 961,456	\$ 961,456	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	21,795	291,003	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,374	5,058	16
17	Accumulated Depreciation (book methods)	(3,589)	(23,656)	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): Capital & Maintenance Escrow	78,000	78,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 98,580	\$ 350,405	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,060,036	\$ 1,311,861	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 753,576	\$ 753,576	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,700	16,700	28
29	Short-Term Notes Payable	710,828	710,828	29
30	Accrued Salaries Payable	102,533	102,533	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	Accrued Payroll Taxes	7,883	7,883	36
37	Due To/From Related Parties	578,184	578,184	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,169,704	\$ 2,169,704	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)	\$ 2,169,704	\$ 2,169,704	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,109,668)	\$ (857,843)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,060,036	\$ 1,311,861	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (543,034)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (543,034)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(566,638)	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	4	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (566,634)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,109,668)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,175,673	1
2	Discounts and Allowances for all Levels	(53,747)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,121,926	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	982,438	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 982,438	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	6,422	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	156,427	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 162,849	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	46	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	10,839	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,839	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,278,098	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	790,738	31
32	Health Care	1,771,110	32
33	General Administration	1,029,166	33
	B. Capital Expense		
34	Ownership	976,653	34
	C. Ancillary Expense		
35	Special Cost Centers	209,179	35
36	Provider Participation Fee	67,890	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,844,736	40
41	Income before Income Taxes (line 30 minus line 40)**	(566,638)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (566,638)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax return prepared on the cash basis.

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

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

Facility Name & ID Number Coventry Village

0047761

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	1,968	2,040	\$ 55,353	\$ 27.13	1
2	Assistant Director of Nursing	2,001	2,202	42,727	19.40	2
3	Registered Nurses	8,478	9,161	199,506	21.78	3
4	Licensed Practical Nurses	15,811	16,633	320,355	19.26	4
5	CNAs & Orderlies	51,176	54,494	521,850	9.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,089	4,299	42,405	9.86	10
11	Social Service Workers	1,912	2,103	32,672	15.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,319	15,433	148,108	9.60	15
16	Dishwashers					16
17	Maintenance Workers	3,932	4,196	60,982	14.53	17
18	Housekeepers	9,191	9,595	81,471	8.49	18
19	Laundry	5,862	6,481	54,732	8.44	19
20	Administrator	2,211	2,243	82,769	36.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,945	4,156	51,361	12.36	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	1,991	2,135	25,770	12.07	31
32	Other Health C: See Sch 20A	5,454	6,011	78,773	13.10	32
33	Other(specify) See Sch 20A	2,267	2,339	27,110	11.59	33
34	TOTAL (lines 1 - 33)	134,607	143,521	\$ 1,825,944 *	\$ 12.72	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	Monthly	\$ 6,790	1(3)	35
36	Medical Director	Monthly	6,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,000	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	Monthly	717	11(3)	44
45	Social Service Consultant	Monthly	1,597	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,104		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		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Conventry Living Center, LLC

Provider #: 0047761

1/1/2007 to 12/31/2007

Schedule 20A

	Hours Worked	Hours Paid	Total Wages	Ave. Hrly. Wage
XVIII. Staffing & Salary Costs				
Line 32 - Other				
Restorative Aide	3,679	4,078	40,385	9.90
Care Plan Coordinator	1,775	1,933	38,388	19.86
	<u>5,454</u>	<u>6,011</u>	<u>78,773</u>	<u>13.10</u>
Line 33 - Other				
Transportation - Bus Driver	1,015	1,015	10,490	10.33
Marketing Wages	1,252	1,324	16,620	12.55
	<u>2,267</u>	<u>2,339</u>	<u>27,110</u>	<u>11.59</u>

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	
Kimberly Welton	Administrator	0	\$ 82,769	Workers' Compensation Insurance	\$ 140,369	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	43,647	Advertising: Employee Recruitment	2,615	
				FICA Taxes	137,022	Health Care Worker Background Check		
				Employee Health Insurance	106,945	(Indicate # of checks performed <u>52</u>)	520	
				Employee Meals		Patient Background Checks	130	
				Illinois Municipal Retirement Fund (IMRF)*		IL Council on Long Term Care	7,217	
				Employee Morale	3,365	Miscellaneous Dues & Subscriptions	1,195	
				Employee Drug Screenings	39	Miscellaneous Licenses & Permits	360	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,769	TOTAL (agree to Schedule V, line 22, col.8)		\$ 431,387	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
SAK Management Services, LLC (Adjusted on Page 6A)			\$ 85,433	N/A			Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 85,433	TOTAL		\$	In-State Travel	
C. Professional Services							Seminar Expense	
Vendor/Payee	Type		Amount					984
See Schedule 21A			\$ 177,321				Allocated from Management Co.	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 177,321				Entertainment Expense	
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 9,961

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Conventry Living Center, LLC

Provider #: 0047761

1/1/2007 to

12/31/2007

Schedule 21A

C. Professional Services

Vendor/Payee	Type	Amount
SAK Management Services, LLC	Bookkeeping Fees	128,149
Aronberg, Goldgehn, Davis & Garmisa	Legal	1,665
Richard Peelo & Associates	Cost Report Preparation	4,200
FR&R	Cost Report Preparation	3,400
FR&R	Accounting	1,190
Joseph Abramchik	Operations Consulting	21,000
Personnel Planners	Unemployment Consultant	1,610
Sharon Haugh	Medicare Consulting	3,600
St. Anthony's Nsg & Rehab	Operations Consulting	1,434
Walnut Grove Village	Operations Consulting	1,308
Alpha Data Services	Data Processing	3,874
Health Data Systems, Inc.	Data Processing	5,579
National Government Services	Data Processing	312
TOTAL (agree to Schedule V, line 19, column 3)		<u>177,321</u>
Allocated from Management Company		
	- Management Fee	(128,149)
	- Legal	3,625
	- Accounting	1,013
	- Data Processing	948
	- Operations Consulting	1,130
TOTAL (agree to Schedule V, line 19, column 8)		<u><u>55,888</u></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	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A						N/A					
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coventry Village# 0047761Report Period Beginning: 01/01/2007Ending: 12/31/2007**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. IL Council on Long Term Care - \$5,514
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,320 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. \$ 67,890
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,422
- (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 The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. 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