

Facility Name & ID Number Coventry Living Center

0047761 Report Period Beginning: 1/1/09 Ending: 7/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>124</u>	Skilled (SNF)	<u>124</u>	<u>26,288</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>6</u>	Sheltered Care (SC)	<u>6</u>	<u>1,272</u>	5
6		ICF/DD 16 or Less			6
7	<u>130</u>	TOTALS	<u>130</u>	<u>27,560</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>264</u>	<u>228</u>	<u>3,041</u>	<u>3,533</u>	8
9	SNF/PED					9
10	ICF	<u>9,426</u>	<u>6,253</u>	<u>499</u>	<u>16,178</u>	10
11	ICF/DD					11
12	SC		<u>817</u>		<u>817</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,690</u>	<u>7,298</u>	<u>3,540</u>	<u>20,528</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.48%

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

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 3/21/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 3/21/06 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 28 and days of care provided 3,041

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: 12/31/09 Fiscal Year: 12/31/09

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

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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	98,625	19,182	4,948	122,755			122,755			1
2	Food Purchase		155,595		155,595			(2,420)	153,175		2
3	Housekeeping	55,545	29,692		85,237				85,237		3
4	Laundry	35,082	18,286		53,368				53,368		4
5	Heat and Other Utilities			106,902	106,902			388	107,290		5
6	Maintenance	44,026	7,163	51,920	103,109				103,109		6
7	Other (specify):*										7
8	TOTAL General Services	233,278	229,918	163,770	626,966			(2,032)	624,934		8
	B. Health Care and Programs										
9	Medical Director			4,500	4,500				4,500		9
10	Nursing and Medical Records	893,172	57,756	5,799	956,727			52,712	1,009,439		10
10a	Therapy			173,703	173,703				173,703		10a
11	Activities	27,967	4,347	5,527	37,841				37,841		11
12	Social Services	25,407		990	26,397				26,397		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	946,546	62,103	190,519	1,199,168			52,712	1,251,880		16
	C. General Administration										
17	Administrative	44,345		158,425	202,770			(158,425)	44,345		17
18	Directors Fees										18
19	Professional Services			43,430	43,430			5,854	49,284		19
20	Dues, Fees, Subscriptions & Promotions			9,281	9,281			576	9,857		20
21	Clerical & General Office Expenses	52,257	14,245	28,754	95,256			3,923	99,179		21
22	Employee Benefits & Payroll Taxes			244,873	244,873				244,873		22
23	Inservice Training & Education							209	209		23
24	Travel and Seminar							11,190	11,190		24
25	Other Admin. Staff Transportation			23,285	23,285			(7,687)	15,598		25
26	Insurance-Prop.Liab.Malpractice			52,708	52,708			1,009	53,717		26
27	Other (specify):* Mgmt Alloc.							11,765	11,765		27
28	TOTAL General Administration	96,602	14,245	560,756	671,603			(131,586)	540,017		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,276,426	306,266	915,045	2,497,737			(80,906)	2,416,831		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.

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			11,526	11,526		11,526	17,927	29,453			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,538	36,538		36,538	(3,236)	33,302			32
33	Real Estate Taxes			74,682	74,682		74,682		74,682			33
34	Rent-Facility & Grounds			478,208	478,208		478,208	3,949	482,157			34
35	Rent-Equipment & Vehicles			32,649	32,649		32,649	951	33,600			35
36	Other (specify):*											36
37	TOTAL Ownership			633,603	633,603		633,603	19,591	653,194			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		84,000		84,000		84,000		84,000			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,024	38,024		38,024		38,024			42
43	Other (specify):* Non-allowable cost	16,505	3,255	142,021	161,781		161,781	(161,781)				43
44	TOTAL Special Cost Centers	16,505	87,255	180,045	283,805		283,805	(161,781)	122,024			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,292,931	393,521	1,728,693	3,415,145		3,415,145	(223,096)	3,192,049			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 Living Center

0047761

Report Period Beginning:

1/1/09

Ending:

7/31/09

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	(2,420)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,436)	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	17,148	30		9
10	Interest and Other Investment Income	(3,794)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(103,340)	43		24
25	Fund Raising, Advertising and Promotional	(13,433)	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 PG5A	(50,657)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (159,932)		\$	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)	(63,164)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (63,164)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (223,096)		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						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	

SEE ACCOUNTANTS' COMPILATION REPORT

Coventry Living Center

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Marketing Salary	\$ (16,505)	43	1
2	Nursing Laboratory	(27,894)	43	2
3	Nursing Diagnostic Imaging	(797)	43	3
4	Cottages	2,731	43	4
5	Non-allowable travel & Entertainment	(8,192)	25	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				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	(50,657)		49

SEE ACCOUNTANTS' COMPILATION REPORT

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	See page 6A	\$			\$	\$	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%	\$ 388	\$ 388
16	V	10 Nursing - Salaries		SAK Management Services, LLC	100.00%	52,712	52,712
17	V	17 Administrative	158,425	SAK Management Services, LLC	100.00%		(158,425)
18	V	19 Professional Services		SAK Management Services, LLC	100.00%	5,854	5,854
19	V	20 Dues, Fees & Subscriptions		SAK Management Services, LLC	100.00%	576	576
20	V	21 Clerical & General		SAK Management Services, LLC	100.00%	3,923	3,923
21	V	23 Inservice Training & Education		SAK Management Services, LLC	100.00%	209	209
22	V	24 Travel & Seminar		SAK Management Services, LLC	100.00%	11,190	11,190
23	V	25 Other Admin. Staff Transportation		SAK Management Services, LLC	100.00%	505	505
24	V	26 Insurance - Property & Liability		SAK Management Services, LLC	100.00%	1,009	1,009
25	V	27 Employee Benefits - Mgmt. Co.		SAK Management Services, LLC	100.00%	11,765	11,765
26	V	30 Depreciation		SAK Management Services, LLC	100.00%	779	779
27	V	34 Rent - Facility & Grounds		SAK Management Services, LLC	100.00%	3,949	3,949
28	V	35 Rent - Equipment & Vehicles		SAK Management Services, LLC	100.00%	951	951
29	V	43 Other		SAK Management Services, LLC	100.00%	893	893
30	V	32 Interest		SAK Management Services, LLC	100.00%	558	558
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 158,425			\$ 95,261	\$ * (63,164)

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

**Related Nursing Homes
As of 7/31/09**

Schedule 6A

Group Name	Facility Name	City
SAK Management	Lena Living Center	Lena
	The Lincoln Home	Belleville
	St. Anthony's Nursing & Rehab Ctr	Rock Island
	Thornton Heights Terrace	Chicago Heights
	Coventry Living Center, LLC	Sterling
	Parkview Terrace	East Moline
	Walnut Grove Village, LLC	Morris
	Woodbine Nursing Home, LLC	Oak Park

See Accountants' Compilation Report

Other Related Business Entities
As of 7/31/09

Schedule 6B

Name	City	Type of Business
SAK Management Services	Chicago	Management Company

See Accountants' Compilation Report

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VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1									\$		1	
2			N/A									2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$			13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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

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 Management Fees	1,513,288	7	\$ 6,164	\$ 95,260	\$ 388	1	
2	10	Nursing - Salaries	SAK Management Fees	1,513,288	7	837,385	837,385	95,260	52,713	2
3	17	Administrative	SAK Management Fees	1,513,288	7		95,260	0	3	
4	19	Professional Services	SAK Management Fees	1,513,288	7	92,992	95,260	5,854	4	
5	20	Dues, Fees & Subscriptions	SAK Management Fees	1,513,288	7	9,149	95,260	576	5	
6	21	Clerical & General	SAK Management Fees	1,513,288	7	62,308	95,260	3,922	6	
7	23	Inservice Training & Education	SAK Management Fees	1,513,288	7	3,317	95,260	209	7	
8	24	Travel & Seminar	SAK Management Fees	1,513,288	7	177,763	95,260	11,190	8	
9	25	Other Admin. Staff Transportatio	SAK Management Fees	1,513,288	7	8,017	95,260	505	9	
10	26	Insurance - Property & Liability	SAK Management Fees	1,513,288	7	16,036	95,260	1,009	10	
11	27	Employee Benefits - Mgmt. Co.	SAK Management Fees	1,513,288	7	186,903	95,260	11,765	11	
12	30	Depreciation	SAK Management Fees	1,513,288	7	12,368	95,260	779	12	
13	34	Rent - Facility & Grounds	SAK Management Fees	1,513,288	7	62,736	95,260	3,949	13	
14	35	Rent - Equipment & Vehicles	SAK Management Fees	1,513,288	7	15,106	95,260	951	14	
15	43	Other	SAK Management Fees	1,513,288	7	14,184	95,260	893	15	
16	32	Interest	SAK Management Fees	1,513,288	7	8,860	95,260	558	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,513,288	\$ 837,385	\$ 95,261	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Coventry Living Center

0047761

Report Period Beginning:

1/1/09

Ending:

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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										
										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	Variable	4/2006	632,835		6/2009	Prime +1	36,538	6							
7	SAK Management	X		Working Capital	Variable	6/2008	64,000	64,000	6/2009	Zero	558	7							
8												8							
9	TOTAL Facility Related						\$ 696,835	\$ 64,000			\$ 37,096	9							
B. Non-Facility Related*																			
10							Interest Income offset				(3,794)	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ (3,794)	14							
15	TOTALS (line 9+line14)						\$ 696,835	\$ 64,000			\$ 33,302	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.)

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,700 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

68 Cottages - Cost not included on cost report

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>N/A</u>			\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

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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	683	10	390	(293)	1,392	9
10	Replace Fire Sprinkler Heads, smoke detector & strobe		2007	4,457	521	10	260	(261)	929	10
11	Roofing - Main Building		2007	10,000	1,020	20	292	(729)	1,042	11
12										12
13	Lessor Additions:									13
14	10 New Heater Pumps		2006	67,093		10	5,869	5,869	25,994	14
15	Windows & Doors Installed		2006	4,934		7	617	617	2,732	15
16	HVAC Unit Installed & Tested		2007	141,149		10	8,234	8,234	29,406	16
17	100 Hall Fire Systems Balanced to meet code		2007	7,887		10	460	460	1,643	17
18	2 Fire Rooms Added on - Walls, Ceiling Tiles, Caulking, etc		2007	27,447		10	1,601	1,601	5,718	18
19	Install 102 and Fix 108 Fire Dampers		2007	14,265		10	832	832	2,972	19
20	Attach and Install New Gas Main		2007	3,800		7	317	317	1,131	20
21	Refurbish Resident Rooms - Tile, Paint, Ceiling Tile, etc		2007	3,285		7	274	274	978	21
22										22
23										23
24	Sidewalk Repair & Removal		2008	3,875	554	10	554		1,108	24
25	Sprinkler System, Fencing, Concrete		2008	2,548	364	7	364		728	25
26	Tile, Kitchen wall repair		2008	4,245	607	7	607		1,214	26
27	Architect & Interior Design		2008	2,910	416	7	416		832	27
28	Replace doors		2008	9,463	1,352	7	1,352		2,704	28
29	Main Building Roofing		2008	13,950	1,993	20	1,993		3,986	29
30	Boiler & Generator		2008	2,746	513	5	513		1,062	30
31	Repair A/C unit, Generator & Boiler		2008	5,225	878	5	878		1,796	31
32	Replace Heat pumps & Flow switches		2008	6,284	977	5	977		1,978	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

Facility Name & ID Number Coventry Living Center

0047761

Report Period Beginning:

1/1/09

Ending:

7/31/09

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)		\$ 342,249	\$ 9,876		\$ 26,797	\$ 16,921	\$ 89,342	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 Living Center

0047761

Report Period Beginning:

1/1/09

Ending:

7/31/09

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	\$ 12,477	\$ 1,650	\$ 1,877	\$ 227		\$ 5,551	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt Co.			779	779			74
75	TOTALS	\$ 12,477	\$ 1,650	\$ 2,656	\$ 1,006		\$ 5,551	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)	\$ 354,726	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 11,526	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,453	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,927	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 94,893	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	\$	1,441	\$ 99,409	\$	1,441	\$ 99,409	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		942	65,027		942	65,027	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		134	9,267		134	9,267	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				84,000		84,000	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			\$	2,517	\$ 173,703	\$ 84,000	2,517	\$ 257,703	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 Living Center

0047761

Report Period Beginning: 1/1/09

Ending: 7/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 7/31/09 (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	\$ 22,625	\$ 22,625	1
2	Cash-Patient Deposits	44,668	44,668	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>215,126</u>)	880,125	880,125	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	80,852	80,852	7
8	Accounts Receivable (owners or related parties)	179,258	179,258	8
9	Other(specify): <u>Cost Report Settlement</u>	42,408	42,408	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,249,936	\$ 1,249,936	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	61,339	338,098	14
15	Leasehold Improvements, at Historical Cost	4,151	4,151	15
16	Equipment, at Historical Cost	17,423	12,477	16
17	Accumulated Depreciation (book methods)	(30,451)	(94,893)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Capital & Maint Escrow</u>	103,614	103,614	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 156,076	\$ 363,447	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,406,012	\$ 1,613,383	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,757,176	\$ 1,757,176	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,022	26,022	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,697	82,697	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	<u>See attached Sch 17A</u>	385,887	385,887	36
37	<u>Due to Walnut Grove Village</u>	979,519	979,519	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,231,301	\$ 3,231,301	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	64,000	64,000	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)	\$ 64,000	\$ 64,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,295,301	\$ 3,295,301	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,889,289)	\$ (1,681,918)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,406,012	\$ 1,613,383	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Coventry Living Center, LLC
1/1/09-7/31/09

Schedule XV. Balance Sheet

Schedule 17A

	Operating	After Consolidation
Due to/from COR	375,887	375,887
Due to/from Chainbridge	10,000	10,000
	<u>385,887</u>	<u>385,887</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,721,314)	1
2	Restatements (describe):		2
3			3
4	Prior period adjustment	2,489	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,718,825)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(170,464)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (170,464)	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)	\$ (1,889,289)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coventry Living Center# 0047761Report Period Beginning: 1/1/09Ending: 7/31/09

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	\$ 2,525,504	1
2	Discounts and Allowances for all Levels	95,611	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,621,115	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	480,846	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 480,846	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	126,931	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)	\$ 126,931	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,794	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,794	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See attached Sch 19A</u>	11,995	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,995	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,244,681	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	626,966	31
32	Health Care	1,199,168	32
33	General Administration	671,603	33
B. Capital Expense			
34	Ownership	633,603	34
C. Ancillary Expense			
35	Special Cost Centers	245,781	35
36	Provider Participation Fee	38,024	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,415,145	40
41	Income before Income Taxes (line 30 minus line 40)**	(170,464)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (170,464)	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 paid on 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.

Coventry Living Center
Provider # 0047761
1/1/09-7/31/09

Schedule 19A

XVII. Income Statement
E. Line 28-Other Income

	<u>Amount</u>
Misc. Income	2,850
Other-MB	2,729
Other Income	<u>6,416</u>
	<u><u>11,995</u></u>

See Accountants' Compilation Report

Facility Name & ID Number **Coventry Living Center**

0047761

Report Period Beginning:

1/1/09

Ending:

7/31/09

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	1,283	1,309	\$ 36,882	\$ 28.18	1
2	Assistant Director of Nursing	844	1,206	27,947	23.17	2
3	Registered Nurses	2,684	2,855	64,333	22.53	3
4	Licensed Practical Nurses	14,470	15,559	303,707	19.52	4
5	CNAs & Orderlies	40,107	42,667	395,521	9.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,432	2,672	26,774	10.02	8
9	Activity Director					9
10	Activity Assistants	2,463	2,831	27,967	9.88	10
11	Social Service Workers	1,637	1,860	25,407	13.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	9,271	9,862	98,625	10.00	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,779	2,895	44,026	15.21	17
18	Housekeepers	5,963	6,481	55,545	8.57	18
19	Laundry	3,907	4,113	35,082	8.53	19
20	Administrator	834	1,191	44,345	37.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,394	6,802	52,257	7.68	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	1,060	1,219	14,696	12.06	31
32	Other Health C: MDS Coordinator	1,205	1,205	23,312	19.35	32
33	Other(specify) <u>Marketing</u>	1,000	1,054	16,505	15.66	33
34	TOTAL (lines 1 - 33)	98,333	105,781	\$ 1,292,931 *	\$ 12.22	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	168	\$ 4,948	1(3)	35
36	Medical Director	120	4,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant	30	1,200	10(3)	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	65	1,295	11(3)	44
45	Social Service Consultant	49	990	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	432	\$ 12,933		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

Facility Name & ID Number Coventry Living Center

0047761

Report Period Beginning: 1/1/09

Ending: 7/31/09

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	
Laurie Alumbaugh	Administrator	0%	\$ 44,345	Workers' Compensation Insurance	\$ 76,877	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	7,092	Advertising: Employee Recruitment	690	
				FICA Taxes	125,796	Health Care Worker Background Check	510	
				Employee Health Insurance	34,071	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks	980	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	4,308	
				Employee Physicals	118	Miscellaneous Licenses & Fees	724	
				Other Employee Benefits	919	Miscellaneous Dues & Subscriptions	79	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 44,345	TOTAL (agree to Schedule V, line 22, col.8)		\$ 9,857		
B. Administrative - Other							Mgmt Co. Alloc	
Description			Amount				Less: Public Relations Expense ()	
SAK Management Services, LLC (eliminated in Sch V col. 7)			\$ 158,425				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 158,425				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Shaw Gussis Fishman Glantz Wolfso Legal			\$ 1,862	N/A			Out-of-State Travel	\$
Aronberg Goldgehn Davis & Garmis Legal			16,240					
Richard Peelo & Associates, Inc.	Cost Report Prep		3,850				In-State Travel	
RSM McGladrey, Inc.	Cost Report Prep		9,100					
Sharon Lofgren	Medicare Billing		1,675				Seminar Expense	
HDSI Health System	A/R System		3,231				Mgmt Co. Alloc	11,190
Payday-USA	Payroll Processing		1,891					
MDI Achieve	Computer Services		5,581				Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 43,430	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Coventry Living Center, LLC
Provider # 0047761
1/1/09-7/31/09

Schedule 21A

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 43,430

SAK Allocation Legal 4,629

SAK Allocation Accounting 145

SAK Allocation Operations Consultant 780

SAK Allocation Computer Tech 300

5,854

Total (agree to Schedule V, line 19, column 8) 49,284

See Accountants' Compilation Report

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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3								N/A					
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 Living Center# 0047761Report Period Beginning: 1/1/09Ending: 7/31/09**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-\$4,308
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,206 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 38,024
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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,420
- (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?
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT