

Facility Name & ID Number Coventry Living Center

0050476 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	13,373	6,819	9,991	30,183	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,373	6,819	9,991	30,183	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.61%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 08/01/09

J. Was the facility purchased or leased after January 1, 1978?
YES Date 08/01/09 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 28 and days of care provided 6,971

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Coventry Living Center # 0050476 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	180,164	58,870	14,678	253,712		253,712	3,093	256,805		1
2	Food Purchase		156,887		156,887		156,887	(331)	156,556		2
3	Housekeeping	130,575	29,776	245	160,596		160,596		160,596		3
4	Laundry	46,988	9,122	153	56,263		56,263		56,263		4
5	Heat and Other Utilities			163,536	163,536		163,536	3,009	166,545		5
6	Maintenance	64,546	38,712	90,241	193,499		193,499	4,671	198,170		6
7	Other (specify):*										7
8	TOTAL General Services	422,273	293,367	268,853	984,493		984,493	10,442	994,935		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,915,813	158,679	14,060	2,088,552		2,088,552		2,088,552		10
10a	Therapy		2,647	658,340	660,987		660,987		660,987		10a
11	Activities	57,069	5,321	8,083	70,473		70,473		70,473		11
12	Social Services	92,586	106		92,692		92,692		92,692		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,065,468	166,753	698,483	2,930,704		2,930,704		2,930,704		16
	C. General Administration										
17	Administrative	117,580		296,419	413,999		413,999	(296,419)	117,580		17
18	Directors Fees										18
19	Professional Services			31,623	31,623		31,623	8,209	39,832		19
20	Dues, Fees, Subscriptions & Promotions			9,553	9,553		9,553	3,373	12,926		20
21	Clerical & General Office Expenses	159,828	41,649	16,110	217,587		217,587	197,235	414,822		21
22	Employee Benefits & Payroll Taxes			404,382	404,382		404,382	331	404,713		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,344	4,344		4,344	3,593	7,937		24
25	Other Admin. Staff Transportation			77,587	77,587		77,587	(38,878)	38,709		25
26	Insurance-Prop.Liab.Malpractice			79,689	79,689		79,689	1,239	80,928		26
27	Other (specify):* HO Alloc Benefits							31,562	31,562		27
28	TOTAL General Administration	277,408	41,649	919,707	1,238,764		1,238,764	(89,755)	1,149,009		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,765,149	501,769	1,887,043	5,153,961		5,153,961	(79,313)	5,074,648		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 Living Center

#0050476

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			10,500	10,500		10,500	3,492	13,992			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							746	746			32
33	Real Estate Taxes			56,766	56,766		56,766	134,882	191,648			33
34	Rent-Facility & Grounds			769,998	769,998		769,998		769,998			34
35	Rent-Equipment & Vehicles			11,865	11,865		11,865	11,154	23,019			35
36	Other (specify):*											36
37	TOTAL Ownership			849,129	849,129		849,129	150,274	999,403			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		207,243		207,243		207,243		207,243			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,192	69,192		69,192		69,192			42
43	Other (specify):* Non-Allowable Cos			153,120	153,120		153,120	(153,120)				43
44	TOTAL Special Cost Centers		207,243	222,312	429,555		429,555	(153,120)	276,435			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,765,149	709,012	2,958,484	6,432,645		6,432,645	(82,159)	6,350,486			45

*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

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				4
5	Telephone, TV & Radio in Resident Rooms	(4,980)	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	202	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	(2,151)	43		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	(63,746)	43		24
25	Fund Raising, Advertising and Promotional	(18,821)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,200)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	29,746			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,950)		\$	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)	(21,209)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (21,209)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (82,159)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Coventry Living Center

ID# 0050476

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Radiology-Other Contracted Services	\$ (943)	43	1
2	Lab-Contract Services	(22,214)	43	2
3	Marketing/Sales-Other Expense	(11,031)	43	3
4	Penalties/Fines	(28,034)	43	4
5	Non-Allowable Home Office Expense	(8,774)	43	5
6	Vending Machine Revenue	3,093	1	6
7	Non-Allowable Home Office Legal Invoices	1,644	19	7
8	Real Estate Tax adjustment	214,882	33	8
9	Removing Airplane Expenses	(38,878)	25	9
10	Non-Allowable Real Estate Taxes	(80,000)	33	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	29,746		49

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
<u>Dominion Management Group, LLC</u>		<u>Mountain Ridge Wellness Center</u>	<u>North Carolina</u>	<u>Coventry Cottages</u>	<u>Sterling, IL</u>	<u>Independent Liv.</u>
<u>- Steve Womack</u>	<u>99</u>	<u>Clemmons Nursing & Rehab</u>	<u>North Carolina</u>	<u>Walnut Grove Cottage</u>	<u>Morris, IL</u>	<u>Independent Liv.</u>
<u>- Barbara Womack</u>	<u>1</u>	<u>Windsor Care Center</u>	<u>Kentucky</u>			
		<u>Blounstown Health & Rehab</u>	<u>Florida</u>			
		<u>Walnut Grove Village</u>	<u>Morris, IL</u>			

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)	
1	V	17 <u>Management Fees</u>	\$ <u>296,419</u>	<u>Dominion Management Group LLC</u>		\$	<u>(296,419)</u>	1
2	V	21 <u>Salaries/Wages</u>		<u>Dominion Management Group LLC</u>		<u>180,702</u>	<u>180,702</u>	2
3	V	27 <u>Employee Benefits</u>		<u>Dominion Management Group LLC</u>		<u>31,562</u>	<u>31,562</u>	3
4	V	21 <u>Clerical/General-Other</u>		<u>Dominion Management Group LLC</u>		<u>12,481</u>	<u>12,481</u>	4
5	V	19 <u>Professional Services</u>		<u>Dominion Management Group LLC</u>		<u>817</u>	<u>817</u>	5
6	V	19 <u>Legal</u>		<u>Dominion Management Group LLC</u>		<u>5,748</u>	<u>5,748</u>	6
7	V	20 <u>Dues/Subs/Licenses</u>		<u>Dominion Management Group LLC</u>		<u>3,373</u>	<u>3,373</u>	7
8	V	43 <u>Other Expenses</u>		<u>Dominion Management Group LLC</u>		<u>8,774</u>	<u>8,774</u>	8
9	V	24 <u>Travel/Seminar</u>		<u>Dominion Management Group LLC</u>		<u>3,593</u>	<u>3,593</u>	9
10	V	21 <u>Office/Other Supplies</u>		<u>Dominion Management Group LLC</u>		<u>4,052</u>	<u>4,052</u>	10
11	V	32 <u>Interest</u>		<u>Dominion Management Group LLC</u>		<u>746</u>	<u>746</u>	11
12	V	26 <u>Insurance</u>		<u>Dominion Management Group LLC</u>		<u>1,239</u>	<u>1,239</u>	12
13	V	6 <u>Maintenance Supplies</u>		<u>Dominion Management Group LLC</u>		<u>2,649</u>	<u>2,649</u>	13
14	Total		\$ <u>296,419</u>			\$ <u>255,736</u>	\$ * <u>(40,683)</u>	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	6 Maintenance Repairs & Other	\$	Dominion Management Group LLC		\$ 2,022	\$	2,022	15
16	V	35 Rent		Dominion Management Group LLC		11,154		11,154	16
17	V	30 Depreciation		Dominion Management Group LLC		3,289		3,289	17
18	V	5 Utilities		Dominion Management Group LLC		3,009		3,009	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 19,474	\$ *	19,474	39

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

Facility Name & ID Number

Coventry Living Center

0050476

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	Steve Womack	Owner	Administrative	99.00		8	17.00	N/A	\$ N/A	N/A	1
2	Barbara Womack	Owner	Administrative	1.00		0	0.00	N/A	N/A	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

Facility Name & ID Number Coventry Living Center

0050476

Report Period Beginning:

1/1/2010

Ending: 2/31/2010

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 Dominion Management Group LLC
 Street Address 1987 8th Avenue NW
 City / State / Zip Code Hickory, NC 28601
 Phone Number (828) 381-4923
 Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Salaries/Wages	Patient Days	209,521	6	\$ 1,222,620	\$ 30,967	\$ 180,702	1
2	27	Employee Benefits	Patient Days	209,521	6	213,546	0	31,562	2
3	21	Clerical/General-Other	Patient Days	209,521	6	84,446	0	12,481	3
4	19	Professional Services	Patient Days	209,521	6	5,526	0	817	4
5	19	Legal	Patient Days	209,521	6	38,893	0	5,748	5
6	20	Dues/Subs/Licenses	Patient Days	209,521	6	22,820	0	3,373	6
7	43	Other Expenses	Patient Days	209,521	6	59,365	0	8,774	7
8	24	Travel/Seminar	Patient Days	209,521	6	24,311	0	3,593	8
9	21	Office/Other Supplies	Patient Days	209,521	6	27,415	0	4,052	9
10	32	Interest	Patient Days	209,521	6	5,046	0	746	10
11	26	Insurance	Patient Days	209,521	6	8,384	0	1,239	11
12	6	Maintenance Supplies	Patient Days	209,521	6	17,925	0	2,649	12
13	6	Maintenance Repairs & Other	Patient Days	209,521	6	13,681	0	2,022	13
14	35	Rent	Patient Days	209,521	6	75,468	0	11,154	14
15	30	Depreciation	Patient Days	209,521	6	22,251	0	3,289	15
16	5	Utilities	Patient Days	209,521	6	20,360	0	3,009	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,862,057	\$ 1,222,620	\$ 275,210	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2009 report. *First year of operation, no prior year accrual.				\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009			\$	271,648
3. Under or (over) accrual (line 2 minus line 1).				\$	271,648
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	
			Cottage Taxes -Non Allowable		(80,000)
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	191,648
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	_____	8		
	2006	_____	9		
	2007	_____	10		
	2008	_____	11		
	2009	_____	12		
Calculation for CY not available					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2009	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coventry Living Center

0050476 Report Period Beginning:

1/1/2010 Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coventry Living Center

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	Plumbing		2009	5,076	338	15	339	1	422	9
10	Plumbing		2010	7,897	461	10	461		461	10
11	Mixing Valves		2009	3,305		15	220	220	257	11
12	Heater Repair		2010	3,450		5	345	345	345	12
13	Generator Repair		2010	4,331		5	433	433	433	13
14	Generator Repair		2010	2,981		5	298	298	298	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

*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					1,023		(1,023)	66
67								67
68								68
69								69
70		\$ 27,040	\$ 1,822		\$ 2,096	\$ 274	\$ 2,217	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

0050476

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<u>55,833</u>	<u>8,678</u>	<u>8,607</u>	<u>(71)</u>	<u>Varies</u>	<u>10,130</u>	72
73	Fully Depreciated Assets							73
74		<u>Home Office Allocation</u>		<u>3,289</u>	<u>3,289</u>			74
75	TOTALS	\$ <u>55,833</u>	\$ <u>8,678</u>	\$ <u>11,896</u>	\$ <u>3,218</u>		\$ <u>10,130</u>	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				\$	\$	\$	\$		\$	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)	\$ 82,873	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 10,500	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 13,992	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,492	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,347	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Wakefield Communities-Sterling

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>130</u>	<u>03/2009</u>	\$ <u>769,998</u>			3
4	Additions						4
5							5
6							6
7	TOTAL	130		\$ 769,998			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 23,019 Description: See Sch 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Schedule 14A

#16

Description	Amount
Maintenance Equipment	915
Admin Equipment	195
Nurse Equipment	4,439
Dish Machine	995
HO Allocation-Rent(equip)	11,154
Other Rent/Lease Expense	<u>5,321</u>
Total Rental Exp.	<u><u>23,019</u></u>

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$	3,606	\$ 259,646	\$	3,606	\$ 259,646	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		728	52,387		728	52,387	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2),(3)	hrs		4,810	346,307	2,647	4,810	348,954	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				207,243		207,243	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			\$	9,144	\$ 658,340	\$ 209,890	9,144	\$ 868,230	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# 0050476Report Period Beginning: 1/1/2010Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(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	\$ 67,575	\$ 67,575	1
2	Cash-Patient Deposits	18,395	18,395	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>82,060</u>)	844,284	844,284	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	10,527	10,527	6
7	Other Prepaid Expenses	2,436	2,436	7
8	Accounts Receivable (owners or related parties)	118,997	118,997	8
9	Other(specify): <u>Real Estate Tax Escrow</u>	92,953	92,953	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,155,167	\$ 1,155,167	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	26,612	27,040	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	55,833	55,833	16
17	Accumulated Depreciation (book methods)	(12,037)	(12,347)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Sch 17</u>	167,638	167,638	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 238,046	\$ 238,164	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,393,213	\$ 1,393,331	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,401,126	\$ 1,401,126	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,395	18,395	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,539	174,539	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	1,900	1,900	35
Other Current Liabilities(specify):				
36	<u>See Sch 17</u>	368,723	368,723	36
37	<u>See Sch 17</u>	244,178	244,178	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,208,861	\$ 2,208,861	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)	\$ 2,208,861	\$ 2,208,861	46
47	TOTAL EQUITY(page 18, line 24)	\$ (815,648)	\$ (815,530)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,393,213	\$ 1,393,331	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Schedule XV. Balance Sheet

Schedule 17A

		After
	Operating	Consolidation
Line 23		
Capital Improvements Escrow	154,440	154,440
Deposits-Utilities	13,198	13,198
	<u>167,638</u>	<u>167,638</u>
Line 36		
Quickcare Suspense Account	(248,923)	(248,923)
W/H-State Income Tax	(124,471)	(124,471)
W/H-Federal Unemployment Taxes	(742)	(742)
W/H-State Unemployment Taxes	(1,111)	(1,111)
W/H-Group Insurance	17,091	17,091
W/H-Employee Advances	186	186
General/Property/Liability Ins	(10,752)	(10,752)
	<u>(368,723)</u>	<u>(368,723)</u>
Line 37		
Receivables-Related Party	(20)	(20)
Due To/From DMG	(654)	(654)
Due To Wakefield	(10,000)	(10,000)
Due To/From Morris SNF Mgt	(233,504)	(233,504)
	<u>(244,178)</u>	<u>(244,178)</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (392,939)	1
2	Restatements (describe):		2
3	Prior Period Adjustment	(69,255)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (462,194)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(353,451)	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	(3)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (353,454)	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)	\$ (815,648)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Coventry Living Center# 0050476Report Period Beginning: 1/1/2010Ending: 12/31/2010

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	\$ 4,068,755	1
2	Discounts and Allowances for all Levels	(806,542)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,262,213	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,293,951	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,293,951	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	76	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	477,429	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,250	19
20	Radiology and X-Ray		20
21	Other Medical Services	10,334	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 505,089	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Sch 19</u>	17,941	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,941	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,079,194	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	984,493	31
32	Health Care	2,930,704	32
33	General Administration	1,238,764	33
B. Capital Expense			
34	Ownership	849,129	34
C. Ancillary Expense			
35	Special Cost Centers	360,363	35
36	Provider Participation Fee	69,192	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,432,645	40
41	Income before Income Taxes (line 30 minus line 40)**	(353,451)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (353,451)	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.

*** 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
01/01/10-12/31/10

Schedule 19A

XVII. Income Statement
E. Line 28-Other Income

	<u>Amount</u>
Transportation - Private	3,740
Transp-Managed Care-B-Fidelis	40
Vending Machine Revenue	3,093
Other Revenue	<u>11,069</u>
	<u><u>17,941</u></u>

See Accountants' Compilation Report

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

0050476

Report Period Beginning: **1/1/2010**

Ending:

12/31/2010

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	2,183	2,183	\$ 66,461	\$ 30.44	1
2	Assistant Director of Nursing	1,862	1,862	59,736	32.08	2
3	Registered Nurses	8,364	8,364	212,205	25.37	3
4	Licensed Practical Nurses	31,626	31,626	688,658	21.78	4
5	CNAs & Orderlies	82,782	82,782	798,170	9.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,631	8,631	57,069	6.61	10
11	Social Service Workers	6,333	6,333	92,586	14.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,055	18,055	180,164	9.98	15
16	Dishwashers					16
17	Maintenance Workers	5,151	5,151	64,546	12.53	17
18	Housekeepers	14,260	14,260	130,575	9.16	18
19	Laundry	5,697	5,697	46,988	8.25	19
20	Administrator	2,640	2,640	117,580	44.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,750	8,750	159,828	18.27	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	2,249	2,249	29,045	12.91	31
32	Other Health C: See Sch. 20A	2,342	2,342	61,538	26.28	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,925	200,925	\$ 2,765,149 *	\$ 13.76	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	193	\$ 13,679	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,150	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	69	4,050	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	262	\$ 39,879		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Coventry Living Center, LLC
01/01/10-12/31/10

Schedule 20A

Ln 32

Name	Hours Worked	Hours Paid	Salary
MDS Coordinator	1,783	1,783	\$ 56,019
Central Supply	559	559	\$ 5,520
Total	<u>2,342</u>	<u>2,342</u>	<u>\$ 61,539</u>

See Accountants' Compilation Report

Schedule 17A

C. Professional Fees

Vendor/Payee	Type	Amount
Brian LaLonde, CPA	Accounting	1,250
Dominion Management	Legal	1,234
Whiteside Co Circu	Legal	25
MDI Achieve Inc-Quickcare	Data Processing	10,040
Paylocity	Payroll Processing	19,075
	Total	<u>31,623</u>

TOTAL (agree to Schedule V, line 19, column 3)

Allocation: Home Office -Professional Fees	817
Allocation: Home Office -Legal Fees	<u>7,392</u>
Total	<u>39,832</u>

TOTAL (agree to Schedule V, line 19, column 8)

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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
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# 0050476Report Period Beginning: 1/1/2010Ending: 12/31/2010**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? N/A
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,537 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. \$ 69,192
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. \$ 331 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT