



Facility Name & ID Number Covenant Health Care Center-Batavia

# 0025577 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

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 \_\_\_\_\_

	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	122	Skilled (SNF)	116	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	116	44,530	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 Public Aid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	8,030	13,673	1,674	23,377	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,030	13,673	1,674	23,377	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.50%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 05/06/80

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 116 and days of care provided 733

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 01/31/2004 Fiscal Year: 01/31/2004

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

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	304,152	23,853	1,620	329,625		329,625	(4,041)	325,584		1
2	Food Purchase		189,229		189,229		189,229		189,229		2
3	Housekeeping	126,046	25,531		151,577		151,577		151,577		3
4	Laundry	39,403	3,770	31,352	74,525		74,525		74,525		4
5	Heat and Other Utilities			160,315	160,315		160,315		160,315		5
6	Maintenance	170,607	29,111	91,661	291,379		291,379		291,379		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	640,208	271,494	284,948	1,196,650		1,196,650	(4,041)	1,192,609		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,560	10,560		10,560		10,560		9
10	Nursing and Medical Records	2,014,073	164,798	18,579	2,197,450		2,197,450		2,197,450		10
10a	Therapy										10a
11	Activities	110,989	14,605	294	125,888		125,888		125,888		11
12	Social Services	83,411	24,628		108,039		108,039		108,039		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,208,473	204,031	29,433	2,441,937		2,441,937		2,441,937		16
	<b>C. General Administration</b>										
17	Administrative	54,194		219,396	273,590		273,590		273,590		17
18	Directors Fees										18
19	Professional Services			49,764	49,764		49,764		49,764		19
20	Dues, Fees, Subscriptions & Promotions			24,837	24,837		24,837		24,837		20
21	Clerical & General Office Expenses	197,630	93,324		290,954		290,954	(53,072)	237,882		21
22	Employee Benefits & Payroll Taxes			593,160	593,160		593,160	(11,769)	581,391		22
23	Inservice Training & Education										23
24	Travel and Seminar			32,431	32,431		32,431	(27,719)	4,712		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			96,556	96,556		96,556		96,556		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	251,824	93,324	1,016,144	1,361,292		1,361,292	(92,560)	1,268,732		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,100,505	568,849	1,330,525	4,999,879		4,999,879	(96,601)	4,903,278		29

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			144,662	144,662		144,662		144,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			231,818	231,818		231,818	(112,129)	119,689			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,644	2,644		2,644		2,644			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			379,124	379,124		379,124	(112,129)	266,995			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	54,537	283,815		338,352		338,352		338,352			39
40	Barber and Beauty Shops			42,339	42,339		42,339		42,339			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,670	65,670		65,670		65,670			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	54,537	283,815	108,009	446,361		446,361		446,361			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	3,155,042	852,664	1,817,658	5,825,364		5,825,364	(208,730)	5,616,634			45

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

**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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,041)	1		4
5	Telephone, TV & Radio in Resident Rooms	(3,315)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				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	(112,129)	32		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	(40,413)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,521)	21		24
25	Fund Raising, Advertising and Promotional	(4,823)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (169,242)		\$	30

OHF USE ONLY					
48		49		50	
				51	
					52

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

		1	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (169,242)		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	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Covenant Health Care Center-Batavia

ID# 0025577

Report Period Beginning: 02/01/2003

Ending: 01/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Non allowable auto and travel	\$ (25,265)	24	1
2	Non allowable seminar expense	(2,454)	24	2
3	Non allowable employee recognition	(11,769)	22	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(39,488)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577

Report Period Beginning:

02/01/2003

Ending:

01/31/2004

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(4,041)	0	0	0	0	0	0	0	0	0	0	(4,041)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,041)</b>	<b>0</b>	<b>(4,041)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(53,072)	0	0	0	0	0	0	0	0	0	0	(53,072)	21
22	Employee Benefits & Payroll Taxes	(11,769)	0	0	0	0	0	0	0	0	0	0	(11,769)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(27,719)	0	0	0	0	0	0	0	0	0	0	(27,719)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(92,560)</b>	<b>0</b>	<b>(92,560)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(96,601)</b>	<b>0</b>	<b>(96,601)</b>	<b>29</b>									

## STATE OF ILLINOIS

Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577

Report Period Beginning:

02/01/2003 Ending:

Summary B

01/31/2004

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(112,129)	0	0	0	0	0	0	0	0	0	0	(112,129)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(112,129)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(112,129)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(208,730)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(208,730)</b>	<b>45</b>

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
Covenant Retirement Communities	100%	See attached schedule	Various	Covenant Retirement	Chicago	Mgt Services

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	17	Management Sevices	\$ 219,396	Covenant Retirement Communities		\$ 219,396	\$	1
2	V								2
3	V	19	Data Processing Services	23,616	Covenant Retirement Communities		23,616		3
4	V	19	Audit Services	9,064	Covenant Retirement Communities		9,064		4
5	V	19	Cost Report Preparation	5,855	Covenant Retirement Communities		5,855		5
6	V	19	Payroll Services	8,355	Covenant Retirement Communities		8,355		6
7	V								7
8	V	22	Pension	16,476	Covenant Retirement Communities		16,476		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 282,762			\$ 282,762	\$ *		14

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

Facility Name & ID Number Covenant Health Care Center-Batavia # 0025577 Report Period Beginning: 02/01/2003 Ending: 01/31/2004

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	NA										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

Facility Name & ID Number Covenant Health Care Center-Batavia

# 0025577

Report Period Beginning: 02/01/2003

Ending: 1/31/2004

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 Covenant Retirement Communities  
 Street Address 5115 N. Francisco Ave  
 City / State / Zip Code Chicago, Illinois 60625  
 Phone Number ( 773)(878-2294  
 Fax Number ( 773)(878-2289

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	17	Management Fees	Net Service Revenue	32	\$ 5,691,819	\$ 2,322,686		\$ 219,396	1
2	19	Data Processing	Fixed Fee Per Mon	32	772,884	Not available		23,616	2
3	19	Auditing Services	Fixed Fee Per Mon	32	312,974	0		9,064	3
4	19	Cost Report Prep	Fixed Fee Per Mon	14	60,960	0		5,855	4
5	19	Payroll Services	Dir Cost	1	8,355	0		8,355	5
6	20	Pension Expense	Dir Cost	1	16,476	0		16,476	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,863,468	\$ 2,322,686		\$ 282,762	25

Facility Name & ID Number

Covenant Health Care Center-Batavia

# 0025577

Report Period Beginning:

02/01/2003

Ending:

01/31/2004

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	See supplemental schedule					\$ 34,433,240	\$ 28,910,824		\$ 849,573	1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>					\$ 34,433,240	\$ 28,910,824		\$ 849,573	9										
<b>B. Non-Facility Related*</b>																				
10	Interest income offset								(729,884)	10										
11										11										
12										12										
13										13										
14	<b>TOTAL Non-Facility Related</b>					\$	\$		\$ (729,884)	14										
15	<b>TOTALS (line 9+line14)</b>					\$ 34,433,240	\$ 28,910,824		\$ 119,689	15										

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # NA

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

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





**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 36,884 B. General Construction Type: Exterior Masonry-Brick Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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			1980	\$ 85,758	1
2					2
3	TOTALS			\$ 85,758	3

**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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	116	1980	1980	\$ 2,546,788	\$	40	\$ 63,669	\$	\$ 1,878,716	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Building Improvements - Michealson		1982	4,706		40	145		3,276	9
10			1983	16,662		20	532		11,432	10
11			1984	832		20			832	11
12			1986	14,644		20			14,644	12
13			1987	12,021		20			12,021	13
14			1988	9,128		20			9,128	14
15			1990	15,226		20			15,226	15
16			1991	40,083		20			40,083	16
17			1992	18,354		20			18,354	17
18			1993	18,931		20			18,931	18
19			1994	90,076		20	4,504		47,290	19
20			1995	56,935		20	2,847		27,044	20
21			1996	84,370		20	4,218		35,856	21
22	Window Treatments		1997	9,674		20	484		3,628	22
23	Cubicle Curtains		1998	4,570		20	228		1,485	23
24	Awnings		1999	5,749		20	287		1,581	24
25	Kitchen updates		2000	5,092		20	255		1,146	25
26	Roof repairs		2001	9,810		20	490		1,716	26
27	Chapel architect services		2003	1,541		20	77		115	27
28	Chapel remodeling		2004	33,456		20	836		836	28
29	Land Improvements - Michealson		1988	1,367		10	69		1,092	29
30			1989	634		10	32		492	30
31			1990	16,549		10	827		11,998	31
32			1991	3,092		10	155		2,088	32
33			1992	13,930		10	697		8,707	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

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)	\$	3,034,220	\$		\$	80,352	\$	2,167,717	70

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

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	
1		\$ 3,034,220	\$		\$ 80,352	\$ 80,352	\$ 2,167,717	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34		\$ 3,034,220	\$		\$ 80,352	\$ 80,352	\$ 2,167,717	34

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

Facility Name & ID Number Covenant Health Care Center-Batavia

# 0025577

Report Period Beginning:

02/01/2003

Ending:

01/31/2004

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	\$ 654,603	\$	\$ 61,496	\$ 61,496		\$ 301,857	71
72	Current Year Purchases	56,253		2,813	2,813		2,813	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 710,856	\$	\$ 64,309	\$ 64,309		\$ 304,670	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)	\$ 3,830,834	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 144,661	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 144,661	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,472,387	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.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

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:				\$ _____			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$ _____			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: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(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	<b>TOTAL</b>		\$ _____	\$ _____	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. \_\_\_\_\_ /2005 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2006 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

\* 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.

**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>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 AIDE _____</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 AIDE _____</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	Nurse Aide Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF AIDES TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	39	96	hrs	\$ 2,714		\$	48	96	\$ 2,762	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	39	1786	hrs	51,822				1,786	51,822	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescripts	283,767					283,767	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				\$ 338,303		\$	48	1,882	\$ 338,351	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 nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Covenant Health Care Center-Batavia**

# **0025577**

Report Period Beginning: **02/01/2003**

Ending: **01/31/2004**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **01/31/2004** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 16,467	\$ 3,240,311	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	297,612	12,698,387	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments		2,105,071	5
6	Prepaid Insurance	5,227		6
7	Other Prepaid Expenses		5,467,091	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Interest</u>	115,322		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 434,628	\$ 23,510,860	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	121,332		13
14	Buildings, at Historical Cost	2,998,653	543,836,211	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	680,462		16
17	Accumulated Depreciation (book methods)	(2,578,999)	(169,246,737)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,121,469	169,432,727	21
22	Other Long-Term Assets (specify):	2,082,753	23,827,025	22
23	Other(specify): <u>Construction in Progress</u>	7,683,585		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 12,109,255	\$ 567,849,226	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 12,543,883	\$ 591,360,086	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ (55,159)	\$ 11,062,086	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		4,104,296	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	273,618	4,995,277	30
31	Accrued Taxes Payable (excluding real estate taxes)		1,337,454	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	128,130	2,095,721	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Current Maturities Ltd.</u>		4,755,664	36
37			1,910,939	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 346,589	\$ 30,261,437	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		275,877,590	39
40	Mortgage Payable			40
41	Bonds Payable	13,639,148		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Inter Company Accounts</u>	(5,605,993)	4,288,942	43
44			17,036,698	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 8,033,155	\$ 297,203,230	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 8,379,744	\$ 327,464,667	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 4,164,138	\$ 263,895,419	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 12,543,883	\$ 591,360,086	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>5,278,710</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>5,278,710</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(1,114,572)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,114,572)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>4,164,138</b>	<b>24</b> *

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

Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577Report Period Beginning: 02/01/2003Ending: 01/31/2004

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,755,200	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,755,200	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	119,240	6
7	Oxygen	12,339	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 131,579	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	53,135	13
14	Non-Patient Meals	4,096	14
15	Telephone, Television and Radio	3,308	15
16	Rental of Facility Space		16
17	Sale of Drugs	329,210	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	28,948	19
20	Radiology and X-Ray		20
21	Other Medical Services	171,989	21
22	Laundry	47,416	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 638,102	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	47,556	24
25	Interest and Other Investment Income***	112,217	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 159,773	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Equipment rental</u>	24,263	28
28a	<u>transportation revenue</u>	1,877	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 26,140	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,710,794	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,196,650	31
32	Health Care	2,441,937	32
33	General Administration	1,361,294	33
<b>B. Capital Expense</b>			
34	Ownership	379,124	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	380,691	35
36	Provider Participation Fee	65,670	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,825,366	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,114,572)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,114,572)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

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

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

Facility Name & ID Number Covenant Health Care Center-Batavia

# 0025577

Report Period Beginning: 02/01/2003

Ending: 01/31/2004

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	1,856	2,080	\$ 74,614	\$ 35.87	1
2	Assistant Director of Nursing	9,424	9,818	270,153	27.52	2
3	Registered Nurses	29,220	31,331	657,963	21.00	3
4	Licensed Practical Nurses	3,012	3,325	66,905	20.12	4
5	Nurse Aides & Orderlies	66,926	69,646	922,820	13.25	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,882	1,913	54,537	28.51	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,223	2,475	36,489	14.74	9
10	Activity Assistants	5,228	5,752	74,500	12.95	10
11	Social Service Workers	4,980	5,262	83,411	15.85	11
12	Dietician					12
13	Food Service Supervisor	5,925	6,553	126,163	19.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,119	17,364	177,988	10.25	15
16	Dishwashers					16
17	Maintenance Workers	8,125	9,002	170,607	18.95	17
18	Housekeepers	11,278	12,479	126,046	10.10	18
19	Laundry	5,110	5,751	39,403	6.85	19
20	Administrator	1,125	1,184	54,194	45.77	20
21	Assistant Administrator					21
22	Other Administrative	2,642	3,182	53,948	16.95	22
23	Office Manager	1,982	2,036	33,090	16.25	23
24	Clerical	6,653	6,847	110,592	16.15	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	1,395	1,417	21,617	15.26	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,105	197,417	\$ 3,155,040 *	\$ 15.98	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	54	\$ 1,619	1-3	35
36	Medical Director	monthly	10,560	9-3	36
37	Medical Records Consultant	80	3,052	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,416	10-3	39
40	Physical Therapy Consultant	36	1,801	10-3	40
41	Occupational Therapy Consultant	52	2,600	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	222	\$ 21,048		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	331	8,271	10-3	52
53	TOTAL (lines 50 - 52)	331	\$ 8,271		53

**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	
Jim Dahl	Administrator	0%	\$ 54,194	Workers' Compensation Insurance	\$ 79,640	IDPH License Fee	\$	
				Unemployment Compensation Insurance	8,954	Advertising: Employee Recruitment	8,186	
				FICA Taxes	212,238	Health Care Worker Background Check	4,038	
				Employee Health Insurance	246,571	(Indicate # of checks performed)		
				Employee Meals		LSN dues	5,681	
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	6,933	
				Group Life Insurance	9,587			
				Pension Plan	16,476			
				Other	7,925			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 54,194	TOTAL (agree to Schedule V, line 22, col.8)		\$ 24,838		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
Covenant Retirement Communities			\$ 219,363				Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 219,363	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount	Amount		
Deloitte & Touche	Auditing Services	\$ 9,064			\$	Out-of-State Travel \$		
ADP	Payroll Services	8,355						
Covenant Retirement	Data Process	23,616				In-State Travel 25,977		
Scutillo	Cost Report	8,353				Non-allowable travel expense (25,265)		
legal		375						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 49,763	TOTAL		\$		
							Seminar Expense 6,453	
							Non-allowable seminar expense (2,454)	
							Entertainment Expense ( )	
							TOTAL (agree to Sch. V, line 24, col. 8) \$ 4,711	

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number Covenant Health Care Center-Batavia# 0025577Report Period Beginning: 02/01/2003 Ending: 01/31/2004**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. LSN \$5681.00
- (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? NA
- (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? NA
- (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? 10Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,242 Line 10
- (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. NA
- (9) Are you presently operating under a sublease agreement? YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO xx 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 of Public Aid during this cost report period. \$ 65,670  
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 of Public Aid, 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. \$ 3,645
- (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. \$ 0%
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- 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? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ NA**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Deloitte & Touche LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? NA  
Attach invoices and a summary of services for all architect and appraisal fees.