

Facility Name & ID Number Covenant Hlth Cr Ctr-Batavia

0025577 Report Period Beginning: 02/01/2004 Ending: 01/31/2005

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	116	Skilled (SNF)	99	42,340	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	116	TOTALS	99	42,340	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF	8,552	20,566	2,655	31,773	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,552	20,566	2,655	31,773	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.04%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES 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 _____ and days of care provided 2,581

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: 01/31/2005 Fiscal Year: 01/31/2005

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

Facility Name & ID Number

Covenant Hlth Cr Ctr-Batavia

0025577

Report Period Beginning:

02/01/2004

Ending:

01/31/2005

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
	A. General Services										
1	Dietary	286,031	22,983	1,818	310,832		310,832	(4,707)	306,125		1
2	Food Purchase		225,885		225,885		225,885		225,885		2
3	Housekeeping	123,105	28,183		151,288		151,288		151,288		3
4	Laundry	41,054	4,511	27,360	72,925		72,925		72,925		4
5	Heat and Other Utilities			143,945	143,945		143,945		143,945		5
6	Maintenance	179,185	34,967	103,271	317,423		317,423		317,423		6
7	Other (specify):*										7
8	TOTAL General Services	629,375	316,529	276,394	1,222,298		1,222,298	(4,707)	1,217,591		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,351,771	207,003	8,548	2,567,322		2,567,322		2,567,322		10
10a	Therapy										10a
11	Activities	124,373	14,615	635	139,623		139,623		139,623		11
12	Social Services	88,597	24,345		112,942		112,942		112,942		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,564,741	245,963	21,183	2,831,887		2,831,887		2,831,887		16
	C. General Administration										
17	Administrative	68,062		255,564	323,626		323,626		323,626		17
18	Directors Fees										18
19	Professional Services				46,956		46,956		46,956		19
20	Dues, Fees, Subscriptions & Promotions				23,459		23,459		23,459		20
21	Clerical & General Office Expenses	203,124	98,375		301,499		301,499	(29,544)	271,955		21
22	Employee Benefits & Payroll Taxes			857,621	857,621		857,621	(12,516)	845,105		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,300	4,300		4,300		4,300		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			128,592	128,592		128,592		128,592		26
27	Other (specify):*										27
28	TOTAL General Administration	271,186	98,375	1,246,077	1,686,053		1,686,053	(42,060)	1,643,993		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,465,302	660,867	1,543,654	5,740,238		5,740,238	(46,767)	5,693,471		29

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

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

Facility Name & ID Number

Covenant Hlth Cr Ctr-Batavia

#0025577

Report Period Beginning:

02/01/2004

Ending:

01/31/2005

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	
	D. Ownership											
30	Depreciation			699,812	699,812		699,812		699,812			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			547,753	547,753		547,753	(114,816)	432,937			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			1,247,565	1,247,565		1,247,565	(114,816)	1,132,749			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	33,292	443,743	109,181	586,216		586,216		586,216			39
40	Barber and Beauty Shops			45,465	45,465		45,465		45,465			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,809	59,809		59,809		59,809			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	33,292	443,743	214,455	691,490		691,490		691,490			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,498,594	1,104,610	3,005,674	7,679,293		7,679,293	(161,583)	7,517,710			45

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

Facility Name & ID Number Covenant Hlth Cr Ctr-Batavia

0025577

Report Period Beginning: 02/01/2004

Ending: 01/31/2005

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
5	Telephone, TV & Radio in Resident Rooms				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				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$		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	TOTAL (C): (sum of lines 38-46)			\$		47

Covenant Hlth Cr Ctr-Batavia

ID# 0025577
 Report Period Beginning: 02/01/2004
 Ending: 01/31/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Interest Income	\$ (114,816)	32	1
2	Employee Recognition	(12,516)	22	2
3	Non care expenses	(27,587)	21	3
4	Non resident meals	(4,707)	1	4
5	Telephone revenue	(1,957)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(161,583)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Hlth Cr Ctr-Batavia

0025577

Report Period Beginning:

02/01/2004

Ending:

01/31/2005

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(4,707)	0	0	0	0	0	0	0	0	0	0	(4,707)	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	TOTAL General Services	(4,707)	0	0	0	0	0	0	0	0	0	0	(4,707)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	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	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
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	(29,544)	0	0	0	0	0	0	0	0	0	0	(29,544)	21
22	Employee Benefits & Payroll Taxes	(12,516)	0	0	0	0	0	0	0	0	0	0	(12,516)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	TOTAL General Administration	(42,060)	0	0	0	0	0	0	0	0	0	0	(42,060)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,767)	0	0	0	0	0	0	0	0	0	0	(46,767)	29

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

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	Management Services	\$ 255,564	Covenant Retirement Communities		\$ 255,564	\$	1
2	V								2
3	V	19	Data Processing Services	16,452	Covenant Retirement Communities		16,452		3
4	V	19	Audit Services	11,246	Covenant Retirement Communities		11,246		4
5	V	19	Cost report preparation	5,496	Covenant Retirement Communities		5,496		5
6	V	19	Payroll Services	8,871	Covenant Retirement Communities		8,871		6
7	V								7
8	V	22	Pension	85,695	Covenant Retirement Communities		85,695		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 383,324			\$ 383,324	\$ *		14

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

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										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 Hlth Cr Ctr-Batavia # 0025577 Report Period Beginning: 02/01/2004 Ending: 1/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management Fees	Net Service Revenue	49	\$ 9,290,618	\$ 2,664,350		\$ 255,564	1
2	19	Data Processing	Fixed Fee Per Mon	49	618,575			16,452	2
3	19	Auditing Services	Fixed Fee Per Mon	49	338,380			11,246	3
4	19	Cost Report Prep	Fixed Fee Per Mon	14	63,456			5,496	4
5	19	Payroll Services	Dir Costs	1	8,871			8,871	5
6	20	Pension Expense	Dir Costs	1	85,695			85,695	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				\$ 10,405,595	\$ 2,664,350		\$ 383,324	25

Facility Name & ID Number Covenant Hlth Cr Ctr-Batavia # 0025577 Report Period Beginning: 02/01/2004 Ending: 01/31/2005

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
	A. Directly Facility Related																			
	Long-Term																			
1	Interest 1992 Tax EE		x	Refinance of Debit		02/01/93	\$ 2,541,247	\$	2012	0.0760	\$ 44,622	1								
2	Interest 1992 Tax EE		x	Refinance of Debit		2/1/93	2,981,169		2022	0.0525	36,841	2								
3	Interest 1998 Tax EE		x	Refinance of Debit		1998	964,084		2015	0.0410	15,127	3								
4	Interest 1998 Tax TE		x	Refinance of Debit		1998	898,564		2015	0.0410	25,981	4								
5	Interest 2001 tax EX Bonds		x	Bldg Const		2001	22,000,000		2031	0.0588	514,544	5								
	Working Capital																			
6	Interest 2002 Tax EEX bonds		x	Refinance of Debit		2028	5,048,176		2028	0.0613	211,704	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 34,433,240	\$			\$ 848,819	9								
	B. Non-Facility Related*																			
10	Non allowable int income										(301,066)	10								
11	Non allowable int income										(114,816)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (415,882)	14								
15	TOTALS (line 9+line14)						\$ 34,433,240	\$			\$ 432,937	15								

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

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

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

Facility Name & ID Number **Covenant Hlth Cr Ctr-Batavia**# **0025577** Report Period Beginning: **02/01/2004** Ending: **01/31/2005****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 2004 report.		\$	1														
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2														
3.	Under or (over) accrual (line 2 minus line 1).		\$	3														
4.	Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4														
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5														
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6														
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7														
Real Estate Tax History:																		
Real Estate Tax Bill for Calendar Year:		2000 _____ 8	<table border="1"> <tr> <td colspan="2">FOR OHF USE ONLY</td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2004 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2004 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR OHF USE ONLY																		
13	FROM R. E. TAX STATEMENT FOR 2004 \$	13																
14	PLUS APPEAL COST FROM LINE 5 \$	14																
15	LESS REFUND FROM LINE 6 \$	15																
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																
	2001 _____ 9																	
	2002 _____ 10																	
	2003 _____ 11																	
	2004 _____ 12																	

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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Hlth Cr Ctr-Batavia COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0025577

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,884 B. General Construction Type: Exterior MasonryBrick 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, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1980	\$ 85,758	1
2					2
3	TOTALS			\$ 85,758	3

Facility Name & ID Number Covenant Hlth Cr Ctr-Batavia

0025577

Report Period Beginning:

02/01/2004 Ending: 01/31/2005

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	99	1980	1980	\$ 2,546,788		40			
5									
6									
7									
8									
Improvement Type**									
9	Building Improvements Michealson		1982	4,706					
10	Building Improvements Michealson		1983	16,662					
11	Building Improvements Michealson		1984	832					
12	Building Improvements Michealson		1986	14,644					
13	Building Improvements Michealson		1987	12,021					
14	Building Improvements Michealson		1988	9,128					
15	Building Improvements Michealson		1990	15,226					
16	Building Improvements Michealson		1991	40,083					
17	Building Improvements Michealson		1992	18,354					
18	Building Improvements Michealson		1993	18,931					
19	Building Improvements Michealson		1994	90,076					
20	Building Improvements Michealson		1995	56,935					
21	Building Improvements Michealson		1996	84,370					
22	Window treatments		1997	9,674					
23	Cubicle Curitns		1998	4,570					
24	Awnings		1999	5,749					
25	kitchen updates		2000	5,092					
26	roof repairs		2001	9,810					
27	Chapel architect services		2003	1,541					
28	Chapel remodeling		2004	33,456					
29	Land improvements		1988	1,367					
30	Land improvements		1999	35,574			1,778		26,155
31									
32									
33									
34									
35									
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		\$	\$		\$	\$	\$
38	Michaelsen Renovation						
39	Site work	2005	511,923				
40	Foundations/slab on grade	2005	352,412				
41	Buidling Cost	2005	4,748,904				
42	Job Services	2005	1,170,344				
43	Construction Fee	2005	321,082				
44	Fee & Permits	2005	62,348				
45	Legal fees	2005	15,062				
46	Architect and engineering fees	2005	719,275				
47	Property development	2005	813,163		623,572		2,766,919
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$	11,750,102	\$	625,350	\$	2,793,074

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

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	\$ 680,462	\$	\$	\$		\$ 304,670	71
72	Current Year Purchases	203,947		74,464	74,464		74,464	72
73	Fully Depreciated Assets	(23,656)					(23,656)	73
74								74
75	TOTALS	\$ 860,753	\$	\$ 74,464	\$ 74,464		\$ 355,478	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	2	
	Reference	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)	\$ 12,696,613	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)	\$ 699,814	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,148,552	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	TOTAL				\$			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	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.	<u> </u> /2006	\$ _____
13.	<u> </u> /2007	\$ _____
14.	<u> </u> /2008	\$ _____

* 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 CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input 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. 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			
		1	2	3	4
		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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39	hrs	\$ 33,292	772	\$ 38,615	\$ 146				772	\$ 72,053	1	
2	Licensed Speech and Language Development Therapist		hrs		120	12,004					120	12,004	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39	hrs		1,170	58,522					1,170	58,522	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39	# of prescripts	443,597								443,597	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			\$ 476,889	2,062	\$ 109,141	\$ 146				2,062	\$ 586,176	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Covenant Hlth Cr Ctr-Batavia

0025577

Report Period Beginning: 02/01/2004

Ending:

01/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/2005

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 230,617	\$ 10,048,000	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	532,688	21,568,000	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments	113,739		5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	16,858		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):	12,575		9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 906,477	\$ 31,616,000	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments	356,218		12
13 Land			13
14 Buildings, at Historical Cost	25,662,404	383,269,000	14
15 Leasehold Improvements, at Historical Cost			15
16 Equipment, at Historical Cost			16
17 Accumulated Depreciation (book methods)	(14,236,499)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds	6,971,938	163,974,000	21
22 Other Long-Term Assets (specify):		33,591,000	22
23 Other(specify):			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 18,754,061	\$ 580,834,000	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,660,538	\$ 612,450,000	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 187,069	\$ 23,855,000	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	114,250		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	173,481		30
31 Accrued Taxes Payable (excluding real estate taxes)	430,827		31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable	47,910		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 <u>Intercompany</u>	2,005,345	270,838,000	36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,958,882	\$ 294,693,000	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	11,073,282	239,963,000	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 11,073,282	\$ 239,963,000	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,032,164	\$ 534,656,000	46
47 TOTAL EQUITY (page 18, line 24)	\$ 5,628,374	\$ 77,794,000	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,660,538	\$ 612,450,000	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,628,374	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,628,374	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	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)	\$ 5,628,374	24 *

* This must agree with page 17, line 47.

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	\$ 5,215,926	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,215,926	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	341,836	6
7	Oxygen	13,646	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 355,482	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	69,339	13
14	Non-Patient Meals	4,707	14
15	Telephone, Television and Radio	1,956	15
16	Rental of Facility Space		16
17	Sale of Drugs	519,607	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,029	19
20	Radiology and X-Ray		20
21	Other Medical Services	241,479	21
22	Laundry	53,464	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 908,581	23
D. Non-Operating Revenue			
24	Contributions	108,444	24
25	Interest and Other Investment Income***	114,661	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 223,105	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	transportation revenue	1,980	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,980	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,705,074	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,222,298	31
32	Health Care	2,831,887	32
33	General Administration	1,686,053	33
B. Capital Expense			
34	Ownership	1,247,565	34
C. Ancillary Expense			
35	Special Cost Centers	631,681	35
36	Provider Participation Fee	59,809	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,679,293	40
41	Income before Income Taxes (line 30 minus line 40)**	(974,219)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (974,219)	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 Hlth Cr Ctr-Batavia

0025577

Report Period Beginning: 02/01/2004

Ending: 01/31/2005

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	\$ 79,199	\$ 38.08	1
2	Assistant Director of Nursing	1,732	1,880	41,377	22.01	2
3	Registered Nurses	32,229	35,587	996,664	28.01	3
4	Licensed Practical Nurses	5,282	5,663	125,224	22.11	4
5	CNAs & Orderlies	72,085	79,851	1,087,612	13.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	512	576	10,279	17.85	9
10	Activity Assistants	7,706	8,518	114,091	13.39	10
11	Social Service Workers	4,756	5,265	88,596	16.83	11
12	Dietician					12
13	Food Service Supervisor	2,928	3,346	65,229	19.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,428	22,718	220,795	9.72	15
16	Dishwashers					16
17	Maintenance Workers	11,221	12,037	179,185	14.89	17
18	Housekeepers	9,781	11,176	123,104	11.02	18
19	Laundry	3,510	3,865	41,053	10.62	19
20	Administrator	1,614	1,795	68,062	37.92	20
21	Assistant Administrator					21
22	Other Administrative	2,513	2,782	53,130	19.10	22
23	Office Manager	1,696	1,880	29,967	15.94	23
24	Clerical	8,938	9,948	120,044	12.07	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	1,155	1,374	21,691	15.79	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Therapist</u>	1,186	1,365	33,292	24.39	33
34	TOTAL (lines 1 - 33)	192,128	211,706	\$ 3,498,594 *	\$ 16.53	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	56	\$ 1,818	1-3	35
36	Medical Director	monthly	12,000	9-3	36
37	Medical Records Consultant	61	2,456	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,416	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	117	\$ 17,690		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	Certified Nurse Assistants/Aides	148	4,676	10-3	52
53	TOTAL (lines 50 - 52)	148	\$ 4,676		53

