FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0013896

Facility Name: St Matthew Center for Health

Address: 1601 North Western Avenue (Number) Park Ridge (City) 60068 (Zip Code)

County: Cook

Telephone Number: (847)825-5531 **Fax #** (847)318-6659

HFS ID Number:

Date of Initial License for Current Owners: 1959

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/09 to 06/30/10 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed)
(Date)
(Print Name and Title) Steven N. Lavenda, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3	39	Intermediate (ICF)	39	14,235	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,326	15,004	8,535	36,865	8
9	SNF/PED					9
10	ICF		4,814		4,814	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,326	19,818	8,535	41,679	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.56%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 1959

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided 7,815

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/10 Fiscal Year: 6/30/10

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	426,872	36,027	168,002	630,901		630,901		630,901			1
2	Food Purchase		334,666		334,666		334,666	(43,844)	290,822			2
3	Housekeeping	170,467	27,725		198,192		198,192		198,192			3
4	Laundry	55,366	11,663	48,459	115,488		115,488		115,488			4
5	Heat and Other Utilities			212,945	212,945		212,945	1,805	214,750			5
6	Maintenance	132,007	11,044	160,772	303,823		303,823	18,937	322,760			6
7	Other (specify):*							1,767	1,767			7
8	TOTAL General Services	784,712	421,125	590,178	1,796,015		1,796,015	(21,335)	1,774,680			8
	B. Health Care and Programs											
9	Medical Director			108,400	108,400		108,400		108,400			9
10	Nursing and Medical Records	3,455,749	103,504	11,047	3,570,300		3,570,300	(30,375)	3,539,925			10
10a	Therapy											10a
11	Activities	212,149	11,166	520	223,835		223,835		223,835			11
12	Social Services	212,054		8,627	220,681		220,681		220,681			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,879,952	114,670	128,594	4,123,216		4,123,216	(30,375)	4,092,841			16
	C. General Administration											
17	Administrative	140,545			140,545		140,545	492,170	632,715			17
18	Directors Fees											18
19	Professional Services			927,935	927,935		927,935	(775,905)	152,030			19
20	Dues, Fees, Subscriptions & Promotions			81,991	81,991		81,991	(49,989)	32,002			20
21	Clerical & General Office Expenses	339,963	74,899	71,822	486,684		486,684	29,519	516,203			21
22	Employee Benefits & Payroll Taxes			1,279,625	1,279,625		1,279,625	98,370	1,377,995			22
23	Inservice Training & Education											23
24	Travel and Seminar			25,784	25,784		25,784	8,593	34,377			24
25	Other Admin. Staff Transportation			8,650	8,650		8,650	7,210	15,860			25
26	Insurance-Prop.Liab.Malpractice			189,319	189,319		189,319	14,407	203,726			26
27	Other (specify):*							30	30			27
28	TOTAL General Administration	480,508	74,899	2,585,126	3,140,533		3,140,533	(175,595)	2,964,938			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,145,172	610,694	3,303,898	9,059,764		9,059,764	(227,305)	8,832,459			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health #0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			426,034	426,034		426,034	34,804	460,838			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			168,813	168,813		168,813	19,356	188,169			32
33	Real Estate Taxes							13	13			33
34	Rent-Facility & Grounds							37,439	37,439			34
35	Rent-Equipment & Vehicles							1,518	1,518			35
36	Other (specify):*			4,175	4,175		4,175		4,175			36
37	TOTAL Ownership			599,022	599,022		599,022	93,130	692,152			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		501,384	928,937	1,430,321		1,430,321		1,430,321			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,070	81,070		81,070	(4,420)	76,650			42
43	Other (specify):*	154,441	14,493	64,839	233,773		233,773	(233,773)				43
44	TOTAL Special Cost Centers	154,441	515,877	1,074,846	1,745,164		1,745,164	(238,193)	1,506,971			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,299,613	1,126,571	4,977,766	11,403,950		11,403,950	(372,368)	11,031,582			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(43,844)	02		4
5	Telephone, TV & Radio in Resident Rooms	(1,112)	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	(795)	30		9
10	Interest and Other Investment Income	(550)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(61,324)	20		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	(281,800)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (389,425)		$	30

BHF 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 Amount	2 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)	17,057		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 17,057		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (372,368)		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

St Matthew Center for Health

ID# 0013896

Report Period Beginning: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Finance Charge	$ (2,538)	21	1
2	Sales to Public	(972)	21	2
3	Misc. Income	(1,246)	21	3
4	Clothing & Personal Supplies	(8,786)	10	4
5	Refund for Discounts on Supplies	(21,589)	10	5
6	Marketing Salary	(96,072)	43	6
7	Non-Care Depreciation	(10,364)	30	7
8	Additional R & M	4,432	06	8
9	Capitalized R&M	(2,544)	06	9
10	Excess Bed Tax	(4,420)	42	10
11	Expenses related to unrelated Hospice Co.	(137,701)	43	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**	(281,800)		49

St Matthew Center for Health

ID# 0013896

Report Period Beginning: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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													1
2	Food Purchase	(43,844)											(43,844)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,805									1,805	5
6	Maintenance	1,888		15,620	1,429								18,937	6
7	Other (specify):*			1,764	3								1,767	7
8	**TOTAL General Services**	(41,956)		19,189	1,432								(21,335)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(30,375)											(30,375)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(30,375)											(30,375)	16
	C. General Administration													
17	Administrative			287,279	110,111	94,780							492,170	17
18	Directors Fees													18
19	Professional Services			(488,854)	(169,461)	(117,590)							(775,905)	19
20	Fees, Subscriptions & Promotions	(61,324)		2,031	8,090	1,214							(49,989)	20
21	Clerical & General Office Expenses	(5,868)		27,564	4,119	3,704							29,519	21
22	Employee Benefits & Payroll Taxes			53,143	25,359	19,868							98,370	22
23	Inservice Training & Education													23
24	Travel and Seminar			2,357	4,519	1,717							8,593	24
25	Other Admin. Staff Transportation			4,772	968	1,470							7,210	25
26	Insurance-Prop.Liab.Malpractice			13,802	328	277							14,407	26
27	Other (specify):*			(13)		43							30	27
28	**TOTAL General Administration**	(67,192)		(97,919)	(15,967)	5,483							(175,595)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(139,523)		(78,730)	(14,535)	5,483							(227,305)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(11,159)		34,033	10,646	1,284							34,804	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(550)		7,880	1,073	10,953							19,356	32
33	Real Estate Taxes			13									13	33
34	Rent-Facility & Grounds			34,961	2,478								37,439	34
35	Rent-Equipment & Vehicles			1,028	61	429							1,518	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(11,709)		77,915	14,258	12,666							93,130	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(4,420)											(4,420)	42
43	Other (specify):*	(233,773)											(233,773)	43
44	**TOTAL Special Cost Centers**	(238,193)											(238,193)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(389,425)		(815)	(277)	18,149							(372,368)	45

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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
LSSI	100	P.A. Peterson	Rockford, IL	Vesper Mgmt. Corp	Des Plaines, IL	Management Co.
				LSSI	Des Plaines, IL	Corporate Office

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 [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages	$	Lutheran Social Services of Illinois - Management Allocation	100.00%	$ 287,279	$ 287,279	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	53,143	53,143	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	24,152	24,152	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Management Allocation	100.00%	16,832	16,832	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	34,961	34,961	19
20	V	5	Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,805	1,805	20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	5	5	21
22	V	32	Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	7,880	7,880	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	13	13	23
24	V	26	Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	13,802	13,802	24
25	V	27	Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%	(13)	(13)	25
26	V	25	Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	4,772	4,772	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	367	367	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,357	2,357	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,031	2,031	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%			30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	661	661	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	15,615	15,615	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%			34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,764	1,764	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	10,732	10,732	36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	34,033	34,033	37
38	V	19	Management Allocation	513,006	Lutheran Social Services of Illinois - Management Allocation	100.00%		(513,006)	38
39	Total			$ 513,006			$ 512,191	$ * (815)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages	$	Lutheran Social Services of Illinois - Human Resources Allocation		$ 110,111	$ 110,111	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Human Resources Allocation		25,359	25,359	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Human Resources Allocation		46,240	46,240	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Human Resources Allocation		4,042	4,042	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Human Resources Allocation		2,478	2,478	19
20	V	5	Utilities		Lutheran Social Services of Illinois - Human Resources Allocation				20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Human Resources Allocation				21
22	V	32	Interest		Lutheran Social Services of Illinois - Human Resources Allocation		1,073	1,073	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Human Resources Allocation				23
24	V	26	Insurance		Lutheran Social Services of Illinois - Human Resources Allocation		328	328	24
25	V	27	Advertising & Promotions		Lutheran Social Services of Illinois - Human Resources Allocation				25
26	V	25	Transportation		Lutheran Social Services of Illinois - Human Resources Allocation		968	968	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Human Resources Allocation		61	61	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Human Resources Allocation		4,519	4,519	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Human Resources Allocation		435	435	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Human Resources Allocation				30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Human Resources Allocation				31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Human Resources Allocation				32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Human Resources Allocation		1,429	1,429	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Human Resources Allocation		7,655	7,655	34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Human Resources Allocation		3	3	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Human Resources Allocation		77	77	36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Human Resources Allocation		10,646	10,646	37
38	V	19	Human Resource Allocation	215,701	Lutheran Social Services of Illinois - Human Resources Allocation			(215,701)	38
39	Total			$ 215,701			$ 215,424	$ * (277)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages	$	Lutheran Social Services of Illinois - Service Network Allocation		$ 94,780	$ 94,780	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Service Network Allocation		19,868	19,868	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Service Network Allocation		21,478	21,478	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Service Network Allocation		3,704	3,704	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Service Network Allocation				19
20	V	5	Utilities		Lutheran Social Services of Illinois - Service Network Allocation				20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Service Network Allocation				21
22	V	32	Interest		Lutheran Social Services of Illinois - Service Network Allocation		10,953	10,953	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Service Network Allocation				23
24	V	26	Insurance		Lutheran Social Services of Illinois - Service Network Allocation		277	277	24
25	V	27	Advertising & Promotions		Lutheran Social Services of Illinois - Service Network Allocation		43	43	25
26	V	25	Transportation		Lutheran Social Services of Illinois - Service Network Allocation		1,470	1,470	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Service Network Allocation				27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Service Network Allocation		1,717	1,717	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Service Network Allocation		1,214	1,214	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Service Network Allocation				30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Service Network Allocation				31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Service Network Allocation		429	429	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Service Network Allocation				33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Service Network Allocation				34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Service Network Allocation				35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Service Network Allocation				36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Service Network Allocation		1,284	1,284	37
38	V	19	Service Network Allocation	139,068	Lutheran Social Services of Illinois - Service Network Allocation			(139,068)	38
39	Total			$ 139,068			$ 157,217	$ * 18,149	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		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 St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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 [X] NO [ ]

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

Name of Related Organization Lutheran Social Services of Illinois
Street Address 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code Des Plaines, Illinois 60018
Phone Number ((847) 635-4600
Fax Number ((847) 635-6764

	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	Salaries & Wages	Non-Capital Direct Costs	36,454,205	265	$ 3,120,995	$ 3,120,995	3,355,505	$ **287,279**	1
2	22	Empl Benefits & Taxes		36,454,205	265	577,344		3,355,505	**53,143**	2
3	19	Prof Fees & Contracts		36,454,205	265	262,382		3,355,505	**24,152**	3
4	21	Supplies, Telephone,		36,454,205	265	182,863		3,355,505	**16,832**	4
5		Postage, Out. Printing		36,454,205	265			3,355,505		5
6	34	Rental of Space		36,454,205	265	379,819		3,355,505	**34,961**	6
7	5	Utilities		36,454,205	265	19,607		3,355,505	**1,805**	7
8	6	Bldg Repairs & Maintenance		36,454,205	265	59		3,355,505	**5**	8
9	32	Interest		36,454,205	265	85,612		3,355,505	**7,880**	9
10	33	Real Estate Taxes		36,454,205	265	144		3,355,505	**13**	10
11	26	Insurance		36,454,205	265	149,947		3,355,505	**13,802**	11
12	27	Advertising & Promotions		36,454,205	265	(143)		3,355,505	**(13)**	12
13	25	Transportation		36,454,205	265	51,838		3,355,505	**4,772**	13
14	35	Car Rental		36,454,205	265	3,984		3,355,505	**367**	14
15	24	Conferences & Conventions		36,454,205	265	25,603		3,355,505	**2,357**	15
16	20	Subscriptions, Dues, Awards		36,454,205	265	22,070		3,355,505	**2,031**	16
17	6	Furniture & Fixtures		36,454,205	265			3,355,505		17
18	6	Machinery & Equipment		36,454,205	265			3,355,505		18
19	35	Equipment Rental		36,454,205	265	7,178		3,355,505	**661**	19
20	6	Equipment Repair & Maint.		36,454,205	265	169,637		3,355,505	**15,615**	20
21	20	Employee Recruitment		36,454,205	265			3,355,505		21
22	7	Security & Waste Removal		36,454,205	265	19,162		3,355,505	**1,764**	22
23	21	All Other Miscellaneous		36,454,205	265	116,590		3,355,505	**10,732**	23
24	30	Depreciation		36,454,205	265	369,734		3,355,505	**34,033**	24
25	**TOTALS**					$ **5,564,425**	$ **3,120,995**		$ **512,191**	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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 [X] NO [ ]

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

Name of Related Organization Lutheran Social Services of Illinois
Street Address 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code Des Plaines, Illinois 60018
Phone Number ((847) 635-4600
Fax Number ((847) 635-6764

	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	Salaries & Wages	Salaries & Benefits	56,594,127	247	$ 945,144	$ 945,144	6,593,325	$ **110,111**	1
2	22	Empl Benefits & Taxes		56,594,127	247	217,667		6,593,325	**25,359**	2
3	19	Prof Fees & Contracts		56,594,127	247	396,906		6,593,325	**46,240**	3
4	21	Supplies, Telephone,		56,594,127	247			6,593,325		4
5		Postage, Out. Printing		56,594,127	247	34,691		6,593,325	**4,042**	5
6	34	Rental of Space		56,594,127	247	21,271		6,593,325	**2,478**	6
7	5	Utilities		56,594,127	247			6,593,325		7
8	6	Bldg Repairs & Maintenance		56,594,127	247			6,593,325		8
9	32	Interest		56,594,127	247	9,206		6,593,325	**1,073**	9
10	33	Real Estate Taxes		56,594,127	247			6,593,325		10
11	26	Insurance		56,594,127	247	2,818		6,593,325	**328**	11
12	27	Advertising & Promotions		56,594,127	247			6,593,325		12
13	25	Transportation		56,594,127	247	8,306		6,593,325	**968**	13
14	35	Car Rental		56,594,127	247	524		6,593,325	**61**	14
15	24	Conferences & Conventions		56,594,127	247	38,790		6,593,325	**4,519**	15
16	20	Subscriptions, Dues, Awards		56,594,127	247	3,730		6,593,325	**435**	16
17	6	Furniture & Fixtures		56,594,127	247			6,593,325		17
18	6	Machinery & Equipment		56,594,127	247			6,593,325		18
19	35	Equipment Rental		56,594,127	247			6,593,325		19
20	6	Equipment Repair & Maint.		56,594,127	247	12,264		6,593,325	**1,429**	20
21	20	Employee Recruitment		56,594,127	247	65,704		6,593,325	**7,655**	21
22	7	Security & Waste Removal		56,594,127	247	26		6,593,325	**3**	22
23	21	All Other Miscellaneous		56,594,127	247	663		6,593,325	**77**	23
24	30	Depreciation		56,594,127	247	91,380		6,593,325	**10,646**	24
25	**TOTALS**					**$ 1,849,090**	**$ 945,144**		**$ 215,424**	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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 [X] NO [ ]

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

Name of Related Organization Lutheran Social Services of Illinois
Street Address 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code Des Plaines, Illinois 60018
Phone Number ((847) 635-4600
Fax Number ((847) 635-6764

	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	Salaries & Wages	Non-Capital Direct Costs	7,027,993	22	$ 198,513	$ 198,513	3,355,505	$ **94,780**	1
2	22	Empl Benefits & Taxes		7,027,993	22	41,612		3,355,505	**19,868**	2
3	19	Prof Fees & Contracts		7,027,993	22	44,985		3,355,505	**21,478**	3
4	21	Supplies, Telephone,		7,027,993	22	7,758		3,355,505	**3,704**	4
5		Postage, Out. Printing		7,027,993	22			3,355,505		5
6	34	Rental of Space		7,027,993	22			3,355,505		6
7	5	Utilities		7,027,993	22			3,355,505		7
8	6	Bldg Repairs & Maintenance		7,027,993	22			3,355,505		8
9	32	Interest		7,027,993	22	22,941		3,355,505	**10,953**	9
10	33	Real Estate Taxes		7,027,993	22			3,355,505		10
11	26	Insurance		7,027,993	22	580		3,355,505	**277**	11
12	27	Advertising & Promotions		7,027,993	22	91		3,355,505	**43**	12
13	25	Transportation		7,027,993	22	3,078		3,355,505	**1,470**	13
14	35	Car Rental		7,027,993	22			3,355,505		14
15	24	Conferences & Conventions		7,027,993	22	3,597		3,355,505	**1,717**	15
16	20	Subscriptions, Dues, Awards		7,027,993	22	2,543		3,355,505	**1,214**	16
17	6	Furniture & Fixtures		7,027,993	22			3,355,505		17
18	6	Machinery & Equipment		7,027,993	22			3,355,505		18
19	35	Equipment Rental		7,027,993	22	898		3,355,505	**429**	19
20	6	Equipment Repair & Maint.		7,027,993	22			3,355,505		20
21	20	Employee Recruitment		7,027,993	22			3,355,505		21
22	7	Security & Waste Removal		7,027,993	22			3,355,505		22
23	21	All Other Miscellaneous		7,027,993	22			3,355,505		23
24	30	Depreciation		7,027,993	22	2,690		3,355,505	**1,284**	24
25	**TOTALS**					$ **329,286**	$ **198,513**		$ **157,217**	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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						$	$		$	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	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		X	Refinance Bldg. Additions		2/16/06	$ 3,752,000	$ 3,403,064	2/16/2028	0.0523	$ 168,813	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Allocation LSSI		X								19,906	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$ 3,752,000	$ 3,403,064			$ 188,719	9
	B. Non-Facility Related*											
10	Interest Income		X								(550)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (550)	14
15	TOTALS (line 9+line14)						$ 3,752,000	$ 3,403,064			$ 188,169	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A 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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health **#** 0013896 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$	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.)	$ 13	2
3. Under or (over) accrual (line 2 minus line 1).	$ 13	3
4. Real Estate Tax accrual used for 2010 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.	$ 13	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

Amount on line 2 is an allocated amount from the LSSI Management Alloocation

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Matthew Center for Health COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013896

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 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 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 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 Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Matthew Center for Health COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013896

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,590 B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 2

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (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).

None

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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	203,354	1958	$ 38,704	1
2					2
3	TOTALS	203,354		$ 38,704	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140		1959	1959	$ 444,500	$	40	$	$	$ 444,500	4
5			1966	1966	315,066		40			315,066	5
6			1976	1976	2,205,040		40	55,126	55,126	1,901,404	6
7			1976	1976	24,547		40	614	614	20,880	7
8			1977	1977	13,438		40	336	336	11,252	8
	Improvement Type**										
9	Various			1978	1,780		20			1,780	9
10	Various			1979	5,380		20			5,380	10
11	Various			1983	152,321		20			152,321	11
12	Various			1984	11,139		20			11,139	12
13	Various			1985	2,400		20			2,400	13
14	Various			1986	7,692		20			7,692	14
15	Various			1987	291,787		20			291,787	15
16	Various			1988	14,914		20			14,914	16
17	Various			1989	253,333		20			253,333	17
18	Various			1990	20,850		20			19,450	18
19	Various			1992	130,569		20			121,369	19
20	Various			1993	453,424		20			453,424	20
21	Various			1994	82,338		20			82,338	21
22	Various			1995	38,246		20			38,246	22
23	Various			1996	5,548		20			5,548	23
24	Various			1997	23,913		20			21,284	24
25	Various			1998	249,986		20	6,828	6,828	159,009	25
26	Various			1999	140,442		20	27	27	135,238	26
27	Various			2000	513,756		20	31,290	31,290	330,265	27
28	Various			2001	1,053,653		20	49,619	49,619	481,119	28
29	Various			2002	112,800		20	11,280	11,280	92,250	29
30	Various			2003	87,810		20	8,782	8,782	61,788	30
31	Various			2004	116,001		20	7,361	7,361	44,342	31
32	Various			2005	595,633		20	29,995	29,995	150,528	32
33	Various			2006	221,398		20	11,070	11,070	47,543	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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)			45,963			(45,963)		68
69	Financial Statement Depreciation			415,670			(415,670)		69
70	TOTAL (lines 4 thru 69)		$ 7,589,704	$ 461,633		$ 212,328	$ (249,305)	$ 5,677,589	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,589,704	$ 461,633		$ 212,328	$ (249,305)	$ 5,677,589	1
2	Boilers & Hot Water Storage Tanks	2007	83,498		20	4,175	4,175	16,700	2
3	Insulate Ductwork On Roof	2007	12,100		20	605	605	2,420	3
4	Exterior Door	2007	5,761		20	288	288	1,152	4
5	Chapel Lane Hot Water Tank Abatement	2007	3,875		20	194	194	775	5
6	Emergency Lighting In Kitchen	2007	3,180		20	159	159	636	6
7	Relocate Alarms & Doorbell	2007	2,180		20	109	109	436	7
8	Pathwys Renovations-Medicare Unit - Carpeting/Flooring	2007	57,042		20	2,852	2,852	11,408	8
9	Laundry Room Door	2007	2,434		20	122	122	487	9
10	Instl. Addtl. Carbon Monoxide Detectors*	2007	5,725		20	286	286	1,145	10
11	Relocation Of Fire System Annunciator*	2007	1,734		20	87	87	347	11
12	Backflow Device For Sprinkler System*	2007	5,940		20	297	297	1,188	12
13	Concrete Pad-Smoking Area*	2007	2,285		20	114	114	457	13
14	Painting & Decorating*	2007	3,582		20	179	179	716	14
15	Additional Smoke Detectors	2007	38,248		20	1,912	1,912	5,737	15
16	Exterior Stairwell Door	2007	4,944		20	247	247	742	16
17	Addtl Smoke Detectors/Fire Alarm System	2007	4,250		20	212	212	637	17
18	Condensing Units For East Building	2007	57,398		20	2,870	2,870	8,610	18
19	Irrigation System	2007	37,500		20	1,875	1,875	5,625	19
20	Pathway-Painting, Nursing Stations,Flooring For Medicare Unit	2007	135,684		20	6,784	6,784	20,353	20
21	Pathway-Painting, Nursing Stations,Flooring For Medicare Unit	2007	99,758		20	4,988	4,988	14,964	21
22	Reconfiguration Of Nurse Call System	2007	3,700		20	185	185	555	22
23	Architect Services-Pathways Renovation	2007	4,495		20	225	225	674	23
24	Canopy Repair	2007	2,785		20	139	139	418	24
25	Insulation Of Piping	2007	7,275		20	364	364	1,091	25
26	Insulation Of Piping	2007	7,000		20	350	350	1,050	26
27	Repair Piping	2007	14,300		20	715	715	2,145	27
28	Window Treatments	2008	19,997		20	1,000	1,000	3,000	28
29	Painting	2008	15,730		20	787	787	2,360	29
30	Window Treatments	2008	56,989		20	2,849	2,849	5,699	30
31	Cubicle Curtains	2008	20,130		20	1,007	1,007	2,013	31
32	Removal Of Carpet/Abatement Process	2008	6,850		20	343	343	685	32
33	Storm Sewer Drainage Repairs	2008	12,985		20	649	649	1,299	33
34	TOTAL (lines 1 thru 33)		$ 8,329,057	$ 461,633		$ 249,296	$ (212,337)	$ 5,793,110	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,329,057	$ 461,633		$ 249,296	$ (212,337)	$ 5,793,110	1
2	Sewage Ejector Pumps	2009	12,850		20	643	643	1,285	2
3	Fire Alarm System	2009	5,833		20	292	292	583	3
4	Carpet For Rooms 17&20	2009	3,550		20	178	178	355	4
5	Painting	2009	3,678		20	184	184	368	5
6	Sewage Ejector Pump	2009	12,850		20	643	643	643	6
7	Plumbing	2009	4,860		20	243	243	243	7
8	Drain & Sewer Repair	2009	3,230		20	162	162	162	8
9	Bathroom Renovation-Demo, Plumbing, Electric, Hvac,Drywall, P	2009	349,257		20	17,463	17,463	17,463	9
10	Front Entrance Door	2010	11,544		20	577	577	577	10
11	Fire Alarm Upgrades	2010	24,768		20	1,238	1,238	1,238	11
12	Nurse Call System Upgrade	2010	19,250		20	963	963	963	12
13	Carpeting	2010	50,623		20	2,531	2,531	2,531	13
14	Fire Alarm Upgrades	2010	6,102		20	305	305	305	14
15	Custrom Nurses Stations	2010	12,172		20	609	609	609	15
16	Carpeting	2010	50,623		20	2,531	2,531	2,531	16
17	Upgrade Lighting	2010	45,596		20	2,280	2,280	2,280	17
18	Pipe Insulation	2010	14,660		20	733	733	733	18
19	Painting	2010	2,544		20	127	127	127	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	TOTAL (lines 1 thru 33)		$ 8,963,046	$ 461,633		$ 280,995	$ (180,638)	$ 5,826,105	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,963,046	$ 461,633		$ 280,995	$ (180,638)	$ 5,826,105	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	TOTAL (lines 1 thru 33)		$ 8,963,046	$ 461,633		$ 280,995	$ (180,638)	$ 5,826,105	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,963,046	$ 461,633		$ 280,995	$ (180,638)	$ 5,826,105	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	TOTAL (lines 1 thru 33)		$ 8,963,046	$ 461,633		$ 280,995	$ (180,638)	$ 5,826,105	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	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	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocation from LSSI			45,963			(45,963)		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								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	TOTAL (12H & 12I lines 1 thru 33)		$	$ 45,963		$	$ (45,963)	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	$ 1,766,995	$	$ 178,280	$ 178,280	10	$ 1,332,413	71
72	Current Year Purchases	15,625		1,562	1,562	10	1,562	72
73	Fully Depreciated Assets	387,278				10	387,278	73
74								74
75	TOTALS	$ 2,169,897	$	$ 179,843	$ 179,843		$ 1,721,254	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)	$ 11,171,648	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 461,633	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 460,838	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (795)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,547,359	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	Pickup Truck - 1900	$ 25,994	$ 3,710	$ 24,579	86
87	Bus - 1900	46,598	6,654	37,409	87
88					88
89					89
90					90
91	TOTALS	$ 72,592	$ 10,364	$ 61,988	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.

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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? ☐ YES ☐ NO
   If NO, see instructions.

		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	Allocation LSSI				37,439			5
6								6
7	TOTAL				$ 37,439 **			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: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 1,090 Description: See Attached Schedule
    (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	Allocation LSSI		$	$ 428	17
18					18
19					19
20					20
21	TOTAL		$	$ 428	21

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

STATE OF ILLINOIS
0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 320,443	$		$ 320,443	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			186,272			186,272	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			367,949			367,949	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			13,126			13,126	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				315,782		315,782	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					41,147	185,602		226,749	13
14	TOTAL			$		$ 928,937	$ 501,384		$ 1,430,321	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number St Matthew Center for Health **#** 0013896 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/10 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	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)**	$	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,975,411	1
2	Discounts and Allowances for all Levels	(336,445)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,638,966	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	507,929	6
7	Oxygen	18,428	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 526,357	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	2,000	13
14	Non-Patient Meals	43,844	14
15	Telephone, Television and Radio	1,112	15
16	Rental of Facility Space		16
17	Sale of Drugs	(60)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(18,699)	21
22	Laundry	20	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 28,217	23
	D. Non-Operating Revenue		
24	Contributions	162,790	24
25	Interest and Other Investment Income***	550	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 163,340	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	539,138	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 539,138	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,896,018	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,796,015	31
32	Health Care	4,123,216	32
33	General Administration	3,140,533	33
	B. Capital Expense		
34	Ownership	599,022	34
	C. Ancillary Expense		
35	Special Cost Centers	1,664,094	35
36	Provider Participation Fee	81,070	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,403,950	40
41	**Income before Income Taxes (line 30 minus line 40)****	(507,932)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (507,932)	43

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

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

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

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,673	1,965	$ 80,605	$ 41.02	1
2	Assistant Director of Nursing	1,680	1,975	72,310	36.61	2
3	Registered Nurses	46,848	52,216	1,607,844	30.79	3
4	Licensed Practical Nurses	11,066	12,421	314,873	25.35	4
5	CNAs & Orderlies	103,007	114,340	1,380,117	12.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,740	1,974	32,419	16.42	9
10	Activity Assistants	14,338	16,078	179,730	11.18	10
11	Social Service Workers	5,057	5,974	101,666	17.02	11
12	Dietician					12
13	Food Service Supervisor	4,282	5,298	72,164	13.62	13
14	Head Cook	4,932	5,683	61,577	10.84	14
15	Cook Helpers/Assistants	28,814	30,934	293,131	9.48	15
16	Dishwashers					16
17	Maintenance Workers	6,970	7,994	132,007	16.51	17
18	Housekeepers	16,018	17,888	170,467	9.53	18
19	Laundry	5,594	6,035	55,366	9.17	19
20	Administrator	1,253	1,560	64,425	41.30	20
21	Assistant Administrator	2,074	2,486	76,120	30.62	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,350	21,926	339,963	15.51	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	13,191	14,564	264,829	18.18	33
34	TOTAL (lines 1 - 33)	283,887	321,311	$ 5,299,613 *	$ 16.49	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 168,002	01-03	35
36	Medical Director	As Needed	108,400	09-03	36
37	Medical Records Consultant	As Needed	3,649	10-03	37
38	Nurse Consultant	As Needed	3,438	10-03	38
39	Pharmacist Consultant	As Needed	3,960	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	As Needed	520	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Chaplain	As Needed	8,627	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 296,596		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trina Springs-Rehder	Administrator		$ 21,028
Steven St. Louis	Administrator		43,397
Kelly Fitzgerald	Assist. Administrator		52,022
Jonathan Moy	Assist. Administrator		24,098
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 140,545

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris	Legal	$ 210
FR&R	Accounting	9,950
Debra Evertsen	Accounting	9,250
Baker Tilly Virchow Krause, LLP	Accounting	39,897
Qquest Software Systems	Computer Software	854
LSSI	Management Services	867,774
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 927,935

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 219,280
Unemployment Compensation Insurance	40,590
FICA Taxes	388,623
Employee Health Insurance	482,030
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	11,466
Life Insurance	9,423
Pension	125,363
Other Benefits	2,850
Allocation LSSI	98,370
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,377,995

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,584
(Indicate # of checks performed 99)	
Patient Background Checks	
Subscriptions & Books	1,747
Membership Dues	17,336
Advertising	61,324
Allocation LSSI	11,335
Less: Public Relations Expense	( )
Non-allowable advertising	(61,324)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,002

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	25,784
Allocation LSSI	8,593
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 34,377

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - $5,329.57**

(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? _____

(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? _____

(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? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **41,200** 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. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **76,650**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **43,844**

(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. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
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? **Yes**
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. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Baker Tilly Virchow Krause,LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.