

		FOR OHF USE				

LL1

**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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.

<p><b>I. IDPH Facility ID Number:</b> <u>0013896</u></p> <p><b>Facility Name:</b> <u>St. Matthew Center for Health</u></p> <p><b>Address:</b> <u>1601 N. Western Ave</u> <u>Park Ridge, Illinois</u> <u>60068</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(847) 825-5531</u> Fax # <u>(847) 318 - 6659</u></p> <p><b>IDPA ID Number:</b> <u>36-2584799 - 001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>1959</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 (C) (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Sonia Channa</u> <b>Telephone Number:</b> <u>(847) 390 - 1411</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 (C) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2004</u> to <u>06/30/2005</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Frederick Aigner</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>President</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) ( ) _____ Fax # ( ) _____</td> </tr> <tr> <td colspan="2"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>          201 S. Grand Avenue East          Springfield, IL 62763-0001 Phone # (217) 782-1630       </td> </tr> </table>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Frederick Aigner</u> (Date) _____		(Title) <u>President</u>	<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) ( ) _____ Fax # ( ) _____	<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																					
<b>IRS Exemption Code</b> <u>501 (C) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																					
	<input type="checkbox"/> "Sub-S" Corp.	_____																																					
	<input type="checkbox"/> Limited Liability Co.	_____																																					
	<input type="checkbox"/> Trust	_____																																					
	<input type="checkbox"/> Other	_____																																					
<b>Officer or Administrator of Provider</b>	(Signed) _____																																						
	(Type or Print Name) <u>Frederick Aigner</u> (Date) _____																																						
	(Title) <u>President</u>																																						
<b>Paid Preparer</b>	(Signed) _____																																						
	(Date) _____																																						
	(Print Name and Title) _____																																						
	(Firm Name & Address) _____																																						
	(Telephone) ( ) _____ Fax # ( ) _____																																						
<b>MAIL TO: BUREAU OF HEALTH FINANCE</b> <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																							

Facility Name & ID Number St. Matthew Center for Health

# 0013896 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 176

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,496	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,296	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		4				
		2 Medicaid Recipient	Private Pay	Other	Total	
8	SNF		25,779	6,905	32,684	8
9	SNF/PED					9
10	ICF	16,371			16,371	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,371	25,779	6,905	49,055	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.30%

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 26 and days of care provided 5,802

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/2005 Fiscal Year: 06/30/2005

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

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	317,464	54,689	139,624	511,777		511,777		511,777		1
2	Food Purchase		224,620		224,620		224,620	2,595	227,215		2
3	Housekeeping	126,087	34,620		160,707		160,707		160,707		3
4	Laundry	48,161	4,997	93,252	146,410		146,410		146,410		4
5	Heat and Other Utilities			148,919	148,919	2,051	150,970		150,970		5
6	Maintenance	184,900	81,961	133,440	400,301	10,328	410,629		410,629		6
7	Other (specify):* Rubish removal			21,493	21,493	1,344	22,837		22,837		7
8	<b>TOTAL General Services</b>	<b>676,612</b>	<b>400,887</b>	<b>536,728</b>	<b>1,614,227</b>	<b>13,723</b>	<b>1,627,950</b>	<b>2,595</b>	<b>1,630,545</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			22,500	22,500		22,500		22,500		9
10	Nursing and Medical Records	3,046,472	656,897	18,634	3,722,003		3,722,003		3,722,003		10
10a	Therapy	60,809		1,029,318	1,090,127		1,090,127		1,090,127		10a
11	Activities	76,807	3,088	1,650	81,545		81,545		81,545		11
12	Social Services	144,559		8,846	153,405		153,405		153,405		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>3,328,647</b>	<b>659,985</b>	<b>1,080,948</b>	<b>5,069,580</b>		<b>5,069,580</b>		<b>5,069,580</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	66,475			66,475	451,234	517,709		517,709		17
18	Directors Fees										18
19	Professional Services			954,942	954,942	(759,753)	195,189	5	195,194		19
20	Dues, Fees, Subscriptions & Promotions			43,833	43,833	16,316	60,149		60,149		20
21	Clerical & General Office Expenses	124,708	45,272	50,373	220,353	33,015	253,368		253,368		21
22	Employee Benefits & Payroll Taxes			1,085,773	1,085,773	104,750	1,190,523		1,190,523		22
23	Inservice Training & Education					15,350	15,350		15,350		23
24	Travel and Seminar			10,940	10,940		10,940		10,940		24
25	Other Admin. Staff Transportation					7,604	7,604		7,604		25
26	Insurance-Prop.Liab.Malpractice			276,665	276,665	21,405	298,070		298,070		26
27	Other (specify):*					85	85	(85)			27
28	<b>TOTAL General Administration</b>	<b>191,183</b>	<b>45,272</b>	<b>2,422,526</b>	<b>2,658,981</b>	<b>(109,994)</b>	<b>2,548,987</b>	<b>(80)</b>	<b>2,548,907</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,196,442</b>	<b>1,106,144</b>	<b>4,040,202</b>	<b>9,342,788</b>	<b>(96,271)</b>	<b>9,246,517</b>	<b>2,515</b>	<b>9,249,032</b>		<b>29</b>

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

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

Facility Name & ID Number St. Matthew Center for Health #0013896 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			374,928	374,928	43,215	418,143	2,943	421,086			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			210,585	210,585	11,674	222,259	(400)	221,859			32
33	Real Estate Taxes					95	95		95			33
34	Rent-Facility & Grounds					38,713	38,713		38,713			34
35	Rent-Equipment & Vehicles			32,116	32,116	2,574	34,690		34,690			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			617,629	617,629	96,271	713,900	2,543	716,443			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			96,263	96,263		96,263		96,263			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			96,263	96,263		96,263		96,263			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,196,442	1,106,144	4,754,094	10,056,680		10,056,680	5,058	10,061,738			45

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

**VI. ADJUSTMENT DETAIL** A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	2,595	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,641	30		9
10	Interest and Other Investment Income	(400)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,778)	19,27,30		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 5,058		\$	30

<b>OHF USE ONLY</b>					
48		49	50	51	52

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 5,058		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

St. Matthew Center for Health

ID# 0013896

Report Period Beginning: 07/01/2004

Ending: 06/30/2005

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Allowable Mgmt & HR Allocation	\$ (2)	19	1
2	Allowable Serv. Network Allocation	7	19	2
3	Management Auto Depreciation	(41)	30	3
4	Non-program auto depreciation	(6,657)	30	4
5	Adjust in Advertising & Promotions- Mgmt	52	27	5
6	Adjust out Advertising & Promotions-Serv Network	(137)	27	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(6,778)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Matthew Center for Health# 0013896

Report Period Beginning:

07/01/2004

Ending:

06/30/2005

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	2,595	0	0	0	0	0	0	0	0	0	0	2,595	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>2,595</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,595</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	5	0	0	0	0	0	0	0	0	0	0	5	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(85)	0	0	0	0	0	0	0	0	0	0	(85)	27
28	<b>TOTAL General Administration</b>	<b>(80)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(80)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>2,515</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2,515</b>	<b>29</b>



Facility Name & ID Number St. Matthew Center for Health

# 0013896

Report Period Beginning: 07/01/2004 Ending: 06/30/2005

**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
N/A	N/A	N/A	N/A	Vesper Mgmt Corp	Des Plaines Illinois	Mgmt co.
				LSSI	Des Plaines Illinois	Corp. 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  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	N/A	\$	N/A		\$	\$	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.

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	<u>N/A</u>								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								<b>TOTAL</b>	\$	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: 07/01/2004Ending: 6/30/2005

## VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	31,532,610	275	\$ 2,761,123	\$ 2,761,123	3,360,293	\$ 294,241	1
2	22	Empl Benefits & Taxes	31,532,610	275	497,832		3,360,293	53,052	2
3	19	Prof Fees & Contract	31,532,610	275	403,737		3,360,293	43,024	3
4	21	Supplies, Telephone	31,532,610	275	219,203		3,360,293	23,360	4
5		Postage, Out. Printing	31,532,610	275	0		3,360,293	0	5
6	34	Rental of Space	31,532,610	275	360,199		3,360,293	38,385	6
7	5	Utilities	31,532,610	275	19,251		3,360,293	2,051	7
8	6	Bldg Repairs & Maintenance	31,532,610	275	49		3,360,293	5	8
9	32	Interest	31,532,610	275	109,551		3,360,293	11,674	9
10	33	Real Estate Taxes	31,532,610	275	892		3,360,293	95	10
11	26	Insurance	31,532,610	275	191,850		3,360,293	20,445	11
12	27	Advertising & Promotions	31,532,610	275	(485)		3,360,293	(52)	12
13	25	Transportation	31,532,610	275	44,827		3,360,293	4,777	13
14	35	Car Rental	31,532,610	275	435		3,360,293	46	14
15	23	Conferences & Conventions	31,532,610	275	135,279		3,360,293	14,416	15
16	20	Subscriptions, Dues, Awards	31,532,610	275	78,643		3,360,293	8,381	16
17	21	Furniture & Fixtures	31,532,610	275	366		3,360,293	39	17
18	6	Machinery & Equipment	31,532,610	275	0		3,360,293	0	18
19	35	Equipment Rental	31,532,610	275	9,487		3,360,293	1,011	19
20	6	Equipment Repair & Maint	31,532,610	275	96,867		3,360,293	10,323	20
21	20	Employee Recruitment	31,532,610	275	(3,214)		3,360,293	(343)	21
22	7	Security & Waste Removal	31,532,610	275	12,609		3,360,293	1,344	22
23	21	All Other Miscellaneous	31,532,610	275	16,334		3,360,293	1,741	23
24	30	Depreciation	31,532,610	275	395,728		3,360,293	42,171	24
25	TOTALS				\$ 5,350,563	\$ 2,761,123		\$ 570,186	25

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2004 Ending: 6/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	47,695,273	247	\$ 849,798	\$ 849,798	5,282,272	\$ 94,115	1
2	22	Empl Benefits & Taxes	47,695,273	247	202,683		5,282,272	22,447	2
3	19	Prof Fees & Contract	47,695,273	247	148,291		5,282,272	16,423	3
4	21	Supplies, Telephone	47,695,273	247	40,999		5,282,272	4,541	4
5		Postage, Out. Printing	47,695,273	247			5,282,272		5
6	34	Rental of Space	47,695,273	247	2,965		5,282,272	328	6
7	5	Utilities	47,695,273	247	(1)		5,282,272		7
8	6	Bldg Repairs & Maintenance	47,695,273	247			5,282,272		8
9	32	Interest	47,695,273	247			5,282,272		9
10	33	Real Estate Taxes	47,695,273	247			5,282,272		10
11	26	Insurance	47,695,273	247	5,025		5,282,272	557	11
12	27	Advertising & Promotions	47,695,273	247			5,282,272		12
13	25	Transportation	47,695,273	247	13,446		5,282,272	1,489	13
14	35	Car Rental	47,695,273	247	1,039		5,282,272	115	14
15	23	Conferences & Conventions	47,695,273	247	4,132		5,282,272	458	15
16	20	Subscriptions, Dues, Awards	47,695,273	247	4,126		5,282,272	457	16
17	21	Furniture & Fixtures	47,695,273	247			5,282,272		17
18	6	Machinery & Equipment	47,695,273	247			5,282,272		18
19	35	Equipment Rental	47,695,273	247	9,120		5,282,272	1,010	19
20	6	Equipment Repair & Maint	47,695,273	247			5,282,272		20
21	20	Employee Recruitment	47,695,273	247	45,807		5,282,272	5,073	21
22	7	Security & Waste Removal	47,695,273	247			5,282,272		22
23	21	All Other Miscellaneous	47,695,273	247	1,061		5,282,272	118	23
24	30	Depreciation	47,695,273	247	6,617		5,282,272	733	24
25	TOTALS				\$ 1,335,108	\$ 849,798		\$ 147,864	25

Facility Name & ID Number St. Matthew Center for Health

# 0013896 Report Period Beginning: 07/01/2004

Ending: 6/30/2005

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	7,037,468	2	\$ 131,685	\$ 131,685	3,360,293	\$ 62,878	1
2	22	Empl Benefits & Taxes	7,037,468	2	61,260		3,360,293	29,251	2
3	19	Prof Fees & Contract	7,037,468	2	20,180		3,360,293	9,636	3
4	21	Supplies, Telephone	7,037,468	2	9,296		3,360,293	4,439	4
5		Postage, Out. Printing	7,037,468	2			3,360,293		5
6	34	Rental of Space	7,037,468	2			3,360,293		6
7	5	Utilities	7,037,468	2			3,360,293		7
8	6	Bldg Repairs & Maintenance	7,037,468	2			3,360,293		8
9	32	Interest	7,037,468	2			3,360,293		9
10	33	Real Estate Taxes	7,037,468	2			3,360,293		10
11	26	Insurance	7,037,468	2	843		3,360,293	403	11
12	27	Advertising & Promotions	7,037,468	2	287		3,360,293	137	12
13	25	Transportation	7,037,468	2	2,802		3,360,293	1,338	13
14	35	Car Rental	7,037,468	2			3,360,293		14
15	23	Conferences & Conventions	7,037,468	2	996		3,360,293	476	15
16	20	Subscriptions, Dues, Awards	7,037,468	2	5,755		3,360,293	2,748	16
17	21	Furniture & Fixtures	7,037,468	2			3,360,293		17
18	6	Machinery & Equipment	7,037,468	2			3,360,293		18
19	35	Equipment Rental	7,037,468	2	822		3,360,293	392	19
20	6	Equipment Repair & Maint	7,037,468	2			3,360,293		20
21	20	Employee Recruitment	7,037,468	2			3,360,293		21
22	7	Security & Waste Removal	7,037,468	2			3,360,293		22
23	21	All Other Miscellaneous	7,037,468	2	(2,561)		3,360,293	(1,223)	23
24	30	Depreciation	7,037,468	2	652		3,360,293	311	24
25	TOTALS				\$ 232,017	\$ 131,685		\$ 110,786	25

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2004 Ending: 06/30/2005

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

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

	1	2	3	4	5	6		7	8	9	10	
						Original	Balance					
	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									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	Tax Exempt Bonds			Refinance Building Additions	N/A	9/23/93	\$ 1,286,188	\$ 2,852,685	8/15/20	0.0738	\$ 210,585	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6	Mgmt Allocation			Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	11,674	6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 1,286,188	\$ 2,852,685			\$ 222,259	9
	<b>B. Non-Facility Related*</b>											
10	Interest Income			Offset against Interest expense	N/A	N/A	N/A	N/A	N/A	N/A	(400)	10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (400)	14
15	<b>TOTALS (line 9+line14)</b>						\$ 1,286,188	\$ 2,852,685			\$ 221,859	15

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

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

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

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2004 report.		\$	N/A																				
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.)		\$																					
3. Under or (over) accrual (line 2 minus line 1).		\$																					
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$																					
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$																					
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$																					
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$																					
Real Estate Tax History:																							
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2000</td><td>8</td></tr> <tr><td>2001</td><td>9</td></tr> <tr><td>2002</td><td>10</td></tr> <tr><td>2003</td><td>11</td></tr> <tr><td>2004</td><td>12</td></tr> </table>	2000	8	2001	9	2002	10	2003	11	2004	12	<table border="1"> <tr><td colspan="2"><b>FOR OHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2004 \$</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td></tr> </table>		<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2004 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
2000	8																						
2001	9																						
2002	10																						
2003	11																						
2004	12																						
<b>FOR OHF USE ONLY</b>																							
13	FROM R. E. TAX STATEMENT FOR 2004 \$																						
14	PLUS APPEAL COST FROM LINE 5 \$																						
15	LESS REFUND FROM LINE 6 \$																						
16	AMOUNT TO USE FOR RATE CALCULATION \$																						

**NOTES:**

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

**IMPORTANT NOTICE**

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

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

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

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions,

**2004 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 Sonia Channa

TELEPHONE 847-390-1411 FAX #: 847 635-6764

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

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

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

**B. Real Estate Tax Cost Allocation:**

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

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

**C. Tax Bills**

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

Facility Name &amp; ID Number St. Matthew Center for Health

# 0013896 Report Period Beginning:

07/01/2004 Ending: 06/30/2005

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,590 B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 2C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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)

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

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

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>	<u>203,354</u>	<u>1958</u>	<u>\$ 38,704</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>203,354</b>		<b>\$ 38,704</b>	<b>3</b>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	176	1959	1959	\$ 444,500	\$	40	\$	\$	\$ 444,500	4
5		1966	1966	315,066	7,877	40	7,877		310,838	5
6		1976	1976	2,205,040	55,126	40	55,126		1,625,774	6
7		1976	1976	24,547	614	40	614		17,810	7
8		1977	1977	13,438	336	40	336		9,572	8
<b>Improvement Type**</b>										
9	1983 Addition		1983	150,179		10			150,179	9
10	1978 Addition		1978	1,780		10			1,780	10
11	1979 Addition		1979	5,380		10			5,380	11
12	1983 Addition		1983	2,142		10			2,142	12
13	1984 Addition		1984	11,139		10			11,139	13
14	1985 Addition		1985	2,400		10			2,400	14
15	1986 Addition		1986	7,692		10			7,692	15
16	1987 Addition		1987	291,787	11,671	25	11,671		247,160	16
17	Renovations		1989	268,451		10			268,451	17
18	ADJUSTMENT PER IDPA - 1989 Renovations		1989	(22,714)		10			(22,714)	18
19	ADJUSTMENT PER IDPA - 1988 Costs		1988	14,914		10			14,914	19
20	Canopy / Western ave.		1992	30,720	1,229	25	1,229		16,604	20
21	Panasonic Camera System		1992	3,720		5			3,720	21
22	New Sidewalk		1992	2,500		10			2,500	22
23	Concrete Loading dock		1992	6,690		10			6,690	23
24	Bathroom Remodeling		1992	13,440		10			13,440	24
25	Chapel Renovation		1992	33,385		10			33,385	25
26	Generator & Mechanical Work		1993	43,564		10			43,564	26
27	New Roof West Building		1993	208,807		10			208,807	27
28	Generator Project & electrical		1993	146,296		10			146,296	28
29	Upgrade West Building Electrical		1993	19,029		10			19,029	29
30	Alzheimer Unit		1992	40,114		10			40,114	30
31	Alzheimer Unit		1993	35,728		10			35,728	31
32	ADJUSTMENT PER IDPA - Alzheimer Unit		1993	(6,025)		10			(6,025)	32
33	ADJUSTMENT PER IDPA - 1990 Improvements OHF		1990	19,450		10			19,450	33
34	Parking Lot Lighting		1994	17,300		10			17,300	34
35	Shower Room Renovation		1994	9,455	433	10	433		9,455	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 &amp; ID Number St. Matthew Center for Health

# 0013896

Report Period Beginning:

07/01/2004 Ending: 06/30/2005

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Rehab Area Renovation	1994	\$ 55,583	\$ 2,547	10	\$ 2,547	\$	\$ 55,583	37
38	Air Conditioning - West Bldg	1995	32,823	2,598	10	2,598		32,823	38
39	Air Conditioning Project - #95-056	1995	5,423	542	10	542		5,174	39
40	ADA Elevator Upgrade	1996	5,548	555	10	555		5,290	40
41	Air Conditioner - Laundry Room	1997	842	84	10	84		650	41
42	Fence & Installation	1997	674	67	10	67		521	42
43	Kitchen A/C & Installation	1997	17,500	1,750	10	1,750		15,168	43
44	Installation of Fire Doors	1997	4,897	196	25	196		1,484	44
45	Landscape Materials	1998	1,600	160	10	160		1,143	45
46	Retainers - Int. Design	1998	3,085	308	10	308		2,153	46
47	Interior Design Fees	1998	1,349	135	10	135		919	47
48	Interior Design Fees	1998	3,000	300	10	300		2,043	48
49	Construction Project	1998	11,282	1,128	10	1,128		7,496	49
50	Painting & Staining	1998	13,725	1,373	10	1,373		9,119	50
51	Painting & Staining	1998	13,723	1,372	10	1,372		9,118	51
52	HVAC/Electrical Upgrade	1998	6,482	648	10	648		4,253	52
53	1998 Addition	1998	170,700	6,828	25	6,828		47,182	53
54	Wall & Door Install - Décor	1999	2,850	285	10	285		1,800	54
55	Architecture, Electrical	1998	10,602	1,060	10	1,060		6,697	55
56	Window Replacement	1998	4,765	476	10	476		3,010	56
57	Energy Study & Admin	1998	1,948	195	10	195		1,230	57
58	HVAC & Admin	1998	3,325	332	10	332		2,100	58
59	Carpet Installation	1999	125,765	12,577	10	12,577		78,370	59
60	MDC Wallcovering	1998	4,400	440	10	440		2,742	60
61	Add-Ons for Lobby Window	1999	1,800	180	10	180		1,122	61
62	Install Wood Veener	1999	894	89	10	89		557	62
63	Paint Sprinkler Pipes	1999	120	12	10	12		75	63
64	Air Conditioning	1999	446	18	25	18		109	64
65	Glass repair - bldg décor project	1999	2,659	266	10	266		1,591	65
66	Remodel 6 resident rooms	1999	720	72	10	72		431	66
67	I20L/F/Roppe & Johnson	1999	170	17	10	17		102	67
68	Installation of Awnings	1999	8,307	831	10	831		4,691	68
69	Couch Wallcovering	1999	61	6	10	6		33	69
70	TOTAL (lines 4 thru 69)		\$ 4,876,983	\$ 114,733		\$ 114,733	\$	\$ 4,011,853	70

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

Facility Name &amp; ID Number St. Matthew Center for Health

# 0013896

Report Period Beginning:

07/01/2004 Ending: 06/30/2005

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12A, Carried Forward</b>	\$ 4,876,983	\$ 114,733		\$ 114,733		\$ 4,011,853		1
2	Installation of Awnings	2000 241	24	10	24		130		2
3	Installation of new windows	2000 35,200	3,520	10	3,520		18,716		3
4	Electric Upgrade	2000 16,253	1,625	10	1,625		10,657		4
5	2000 Addition	2000 49,564	4,956	10	4,956		25,107		5
6	Door to laundry	2000 5,995	600	10	600		2,988		6
7	Furniture & Flooring	2001 341,679	34,168	10	34,168		170,281		7
8	Cable tv system	2001 15,169	1,517	10	1,517		7,303		8
9	Awning Installation	2001 235,000	23,500	10	23,500		117,116		9
10	Exahust Fans Replacement	2001 6,055	606	10	606		3,018		10
11	Air Conditioning Project	2001 88	4	25	4		18		11
12	Air Conditioning project	2001 107,325	4,293	25	4,293		21,435		12
13	Air Conditioning project	2001 253,678	10,147	25	10,147		50,663		13
14	Signs Internally V Shaped	2001 20,570	2,057	10	2,057		10,251		14
15	Air Conditioning project	2001 147,096	5,884	25	5,884		28,378		15
16	Installation of private Cable System	2001 15,170	1,517	10	1,517		7,560		16
17	Seal Coating- St	2001 5,150	206	25	206		994		17
18	Boiler Set Up	2001 214,651	8,586	25	8,586		41,411		18
19	Facility Upgrades	2001 1,509	151	10	151		714		19
20	Facility Upgrades	2001 774	77	10	77		366		20
21	St Matts Air Conditioning	2001 78,348	3,134	25	3,134		14,591		21
22	Windows & Screen Replacement	2001 1,683	168	10	168		768		22
23	Facility Upgrades Cable	2001 5,467	547	10	547		2,496		23
24	Air Conditioning Project	2001 4,715	189	25	189		847		24
25	Air Conditioning Project	2001 11,400	456	25	456		2,008		25
26	Garbage Disposers	2001 3,512	351	10	351		1,487		26
27	Install chilled water cooler	2001 103,301	4,132	25	4,132		16,839		27
28	Fix Door and Wall	2001 3,280	131	25	131		666		28
29	Update Fire Panel	2000 7,051	705	10	705		2,868		29
30	Valve Project	2001 3,370	135	25	135		538		30
31	Counter Tops	2001 43,338	4,334	10	4,334		16,905		31
32	Windows & Screen	2001 1,683	168	10	168		656		32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 6,615,298	\$ 232,621		\$ 232,621		\$ 4,589,628		34

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

Facility Name &amp; ID Number St. Matthew Center for Health

# 0013896

Report Period Beginning:

07/01/2004 Ending: 06/30/2005

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12B, Carried Forward</b>	\$ 6,615,298	\$ 232,621		\$ 232,621		\$ 4,589,628		1
2	Tree Removal	2001 2,550	255	10	255		910		2
3	Facility Upgrade	2002 37,600	3,760	10	3,760		12,777		3
4	Facility Upgrade	2002 75,200	7,520	10	7,520		23,073		4
5	Tuckpointing	2003 8,555	856	10	856		1,890		5
6	Masonry Restoration	2003 47,520	4,752	10	4,752		9,704		6
7	Parking Lot Improvements	2003 7,725	773	10	773		1,578		7
8	FY 89 IDPA Audit - Phone System Amplifiers	1989 491		5			491		8
9	FY 89 IDPA Audit - Garbage Disposer	1989 2,654		5			2,654		9
10	FY 89 IDPA Audit - Ceiling Fans	1989 2,724		7			2,724		10
11	FY 89 IDPA Audit - Toilet Frames	1989 734		5			734		11
12	FY 89 IDPA Audit - Air Conditioner	1989 993		5			993		12
13	LANDSCAPING PHASE 1	2003 10,780	1,078	10	1,078		2,113		13
14	LANDSCAPING PHASE 1	2003 10,780	1,078	10	1,078		2,113		14
15	WINDOW REPAIRS	2003 2,450	245	10	245		480		15
16	COURT YARD CONCRETE REPAIRS	2004 7,676	768	10	768		799		16
17	WINDOW REPAIRS FROM BUILDING SHIFTING	2004 7,160	716	10	716		745		17
18	WINDOW REPLACEMENT	2004 5,648	565	10	565		591		18
19	REMODELING OF MAIN & SMALL DINING ROOM	2004 52,000	2,080	25	2,080		2,164		19
20	REMODELING OF MAIN & SMALL DINING ROOMS	2004 3,804	152	25	152		158		20
21									21
22	COURT YARD CONCRETE REPAIRS	2005 7,676	768	10	768		768		22
23	WINDOW REPLACEMENT	2005 8,472	847	10	847		847		23
24	SEAL AND RESTRIPE PARKING LOT	2004 23,565	1,465	10	1,465		1,465		24
25	SIDEWALK REPAIRS	2005 650	8	10	8		8		25
26	FITNESS CENTER & COMPUTER RM/JUICE BAR	2005 15,099	177	25	177		177		26
27	FITNESS CENTER & COMPUTER RM/JUICE BAR	2005 11,746	138	25	138		138		27
28	FITNESS CENTER & COMPUTER RM	2005 5,650	66	25	66		66		28
29	FITNESS CENTER & COMPUTER RM	2005 64,645	106	25	106		106		29
30	COMMON AREAS DECORATING	2005 7,900	65	5	65		65		30
31									31
32	Management Assets - Security System	1999 55,002		10	205	205	N/A		32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 7,102,747	\$ 260,859		\$ 261,064	\$ 205	\$ 4,659,959		34

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

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	\$ 1,325,383	\$ 105,910	\$ 145,716	\$ 39,806	Various	\$ 469,732	71
72	Current Year Purchases	75,220	9,843	13,006	3,163	Various	13,006	72
73	Fully Depreciated Assets	396,729				Various	396,729	73
74								74
75	TOTALS	\$ 1,797,332	\$ 115,753	\$ 158,722	\$ 42,969		\$ 879,467	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	Resident Transp.	1997 Champion Challenger	1997	\$ 54,610	\$ 1,300	\$ 1,300		7	\$ 54,610	76
77										77
78										78
79										79
80	TOTALS			\$ 54,610	\$ 1,300	\$ 1,300			\$ 54,610	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,993,393	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 377,912	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 421,086	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 43,174	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,594,036	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	1990 Ford Paratransit Van	\$ 36,850		\$ 36,850	86
87	Pickup Truck	25,994	3,713	6,031	87
88	Bus	46,598	6,657	6,657	88
89	Management Autos	2,287	41	N/A	89
90					90
91	TOTALS	\$ 111,729	\$ 10,411	\$ 49,538	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95			95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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								5
6								6
7	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_ /2006 \$ \_\_\_\_\_  
13. \_\_\_\_\_ /2007 \$ \_\_\_\_\_  
14. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

8. List separately any amortization of lease expense included on page 4, line 34. N/A  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 32,116 Description: See Attached Schedule  
(Attach a schedule detailing the breakdown of movable equipment)

\* 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.

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

- (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.

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	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		hrs	\$		\$	\$			1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs	N/A						7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

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

STATE OF ILLINOIS

Facility Name & ID Number    St. Matthew Center for Health    #    0013896    Report Period Beginning:    07/01/2004    Ending:    06/30/2005  
 XV. BALANCE SHEET - Unrestricted Operating Fund.    As of    06/30/2005    (last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	1
2	Cash-Patient Deposits		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	N / A	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):		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	10
<b>B. Long-Term Assets</b>			
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):		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
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
<b>Other Current Liabilities(specify):</b>			
36			36
37			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	38
<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ N / A	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
<b>A. Additions (deductions):</b>			
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>B. Transfers (Itemize):</b>			
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 *

Note:

Lutheran Social Services of Illinois is unable to provide meaningful comparative balance sheets or statements of changes in equity for individual programs due to the commingling of cash, other

assets, and most liabilities in a complex, multi-funtional service agency. Any balance sheet prepared with only those assets, liabilities and fund balances identifiable with specific programs would not balance or ptesent a meaningful picture of that program's financial status.

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number St. Matthew Center for Health

# 0013896

Report Period Beginning: 07/01/2004

Ending:

Page 19

06/30/2005

**VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,826,190	1
2	Discounts and Allowances for all Levels	(379,465)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,446,725	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	2,200	13
14	Non-Patient Meals	2,595	14
15	Telephone, Television and Radio	4,210	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 9,005	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	277,160	24
25	Interest and Other Investment Income***	400	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 277,560	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Cookie Sales</u>	6,282	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,282	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,739,572	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,614,227	31
32	Health Care	5,069,580	32
33	General Administration	2,658,981	33
<b>B. Capital Expense</b>			
34	Ownership	617,629	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	96,263	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,056,680	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(317,108)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (317,108)	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.

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

Facility Name &amp; ID Number St. Matthew Center for Health

# 0013896

Report Period Beginning: 07/01/2004

Ending: 06/30/2005

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,412	1,623	\$ 57,268	\$ 35.29	1
2	Assistant Director of Nursing	7,713	8,486	101,538	11.97	2
3	Registered Nurses	46,977	51,770	1,340,942	25.90	3
4	Licensed Practical Nurses	31,111	35,512	489,783	13.79	4
5	CNAs & Orderlies	85,004	91,335	975,347	10.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,673	6,270	60,809	9.70	8
9	Activity Director	4,400	4,839	76,807	15.87	9
10	Activity Assistants					10
11	Social Service Workers	5,522	6,055	98,420	16.25	11
12	Dietician					12
13	Food Service Supervisor	3,698	4,169	53,075	12.73	13
14	Head Cook	5,544	6,424	58,920	9.17	14
15	Cook Helpers/Assistants	24,946	26,914	205,469	7.63	15
16	Dishwashers					16
17	Maintenance Workers	8,997	9,873	184,900	18.73	17
18	Housekeepers	15,651	16,587	126,087	7.60	18
19	Laundry	4,665	5,258	48,161	9.16	19
20	Administrator					20
21	Assistant Administrator	1,806	2,033	66,475	32.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,370	9,373	118,646	12.66	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	6,942	7,569	81,597	10.78	31
32	Other Health Care(specify)					32
33	Other(specify)	2,114	2,342	52,198	22.29	33
34	TOTAL (lines 1 - 33)	270,545	296,432	\$ 4,196,442 *	\$ 14.16	34

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

\*\* See instructions.

## B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	As Needed	\$ 139,624	1,3	35
36	Medical Director	As Needed	22,500	9,3	36
37	Medical Records Consultant	As Needed	4,176	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	1,936	10,3	39
40	Physical Therapy Consultant	As Needed	632,331	10a,3	40
41	Occupational Therapy Consultant	As Needed	235,691	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	161,067	10a,3	43
44	Activity Consultant	As Needed	2,334	10a,3	44
45	Social Service Consultant				45
46	Other(specify) Chaplin / Dental	As Needed	22,623	Various	46
47	Legal & Audit Accounting	As Needed	126,111	19,3	47
48	Laundry Services	As Needed	93,252	4,3	48
49	TOTAL (lines 35 - 48)		\$ 1,441,645		49

## C. CONTRACT NURSES

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





Facility Name & ID Number St. Matthew Center for Health# 0013896Report Period Beginning: 07/01/2004Ending: 06/30/2005**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network \$6157
- (3) Did the nursing home make political contributions or payments to a political 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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,797 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  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 96,263  
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,595
- (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? 0%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Clifton Gunderson LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. In Progress, will send as soon as avail
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.