

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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.

I. IDPH Facility ID Number: 0013896

Facility Name: St Matthew Center for Health

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

County: Cook

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

HFS ID Number: 36-2584799-001

Date of Initial License for Current Owners: 1959

Type of Ownership:

<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
IRS Exemption Code <u>501 (C) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u> </u>
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other <u> </u>	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/05 to 06/30/06 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) <u>Steven N. Lavenda, C.P.A.</u>	
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	

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: 07/01/05 Ending: 06/30/06

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 8/18/05

	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)	119	43,483	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	47	17,587	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	166	61,070	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		29,219	7,469	36,688	8
9	SNF/PED					9
10	ICF	17,178			17,178	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,178	29,219	7,469	53,866	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.20%

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

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 30 and days of care provided 7,469

Medicare Intermediary AdminaStar Federa;

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/05 Fiscal Year: 6/30/05

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	346,058	69,577	137,867	553,502		553,502		553,502		1
2	Food Purchase		230,117		230,117		230,117	(3,928)	226,189		2
3	Housekeeping	136,557	52,449		189,006		189,006		189,006		3
4	Laundry	50,082	6,827	123,295	180,204		180,204		180,204		4
5	Heat and Other Utilities			224,274	224,274		224,274	2,370	226,644		5
6	Maintenance	182,450	16,275	161,972	360,697		360,697	(7,701)	352,996		6
7	Other (specify):*							1,403	1,403		7
8	TOTAL General Services	715,147	375,245	647,408	1,737,800		1,737,800	(7,856)	1,729,944		8
	B. Health Care and Programs										
9	Medical Director			52,600	52,600		52,600		52,600		9
10	Nursing and Medical Records	3,752,754	121,263	3,802	3,877,819		3,877,819	(1,487)	3,876,332		10
10a	Therapy	46,188			46,188		46,188		46,188		10a
11	Activities	96,407	6,465	1,354	104,226		104,226		104,226		11
12	Social Services	168,365	373	48,684	217,422		217,422		217,422		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,063,714	128,101	106,440	4,298,255		4,298,255	(1,487)	4,296,768		16
	C. General Administration										
17	Administrative	70,717		890,746	961,463		961,463	(591,639)	369,824		17
18	Directors Fees										18
19	Professional Services			29,473	29,473		29,473	78,814	108,287		19
20	Dues, Fees, Subscriptions & Promotions			54,267	54,267		54,267	(31,314)	22,953		20
21	Clerical & General Office Expenses	97,573	55,285	282,969	435,827		435,827	218,442	654,269		21
22	Employee Benefits & Payroll Taxes			1,333,748	1,333,748		1,333,748		1,333,748		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,868	6,868		6,868	16,612	23,480		24
25	Other Admin. Staff Transportation			10,021	10,021		10,021	9,571	19,592		25
26	Insurance-Prop.Liab.Malpractice			266,523	266,523		266,523	24,882	291,405		26
27	Other (specify):*							107,620	107,620		27
28	TOTAL General Administration	168,290	55,285	2,874,615	3,098,190		3,098,190	(167,012)	2,931,178		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,947,151	558,631	3,628,463	9,134,245		9,134,245	(176,355)	8,957,890		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: 07/01/05 Ending: 06/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			403,197	403,197	403,197	43,686	446,883				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			164,858	164,858	164,858	11,257	176,115				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						37,610	37,610				34
35	Rent-Equipment & Vehicles			1,857	1,857	1,857	2,498	4,355				35
36	Other (specify):*			29,477	29,477	29,477		29,477				36
37	TOTAL Ownership			599,389	599,389	599,389	95,051	694,440				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		539,211	676,431	1,215,642	1,215,642		1,215,642				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			97,200	97,200	97,200	(5,595)	91,605				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		539,211	773,631	1,312,842	1,312,842	(5,595)	1,307,247				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,947,151	1,097,842	5,001,483	11,046,476	11,046,476	(86,899)	10,959,577				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: 07/01/05

Ending: 06/30/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,928)	02		4
5	Telephone, TV & Radio in Resident Rooms	(2,471)	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	16,566	30		9
10	Interest and Other Investment Income	(233)	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	(40,845)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,114)	20		28
29	Other-Attach Schedule	(52,647)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (87,672)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	773		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 773		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (86,899)		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line	Reference
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
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86			86
87			87
88			88
89			89
90			90
91			91
92			92
93			93
94			94
95			95
96			96
97			97
98			98
99			99
100			100
101			101
Total	(52,647)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning:

07/01/05

Ending:

06/30/06

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(3,928)											(3,928)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			2,342	28								2,370	5
6	Maintenance	(21,645)		13,791	153								(7,701)	6
7	Other (specify):*			1,396	7								1,403	7
8	TOTAL General Services	(25,573)		17,529	188								(7,856)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,487)											(1,487)	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	(1,487)											(1,487)	16
	C. General Administration													
17	Administrative			(259,629)	(224,475)	(107,535)							(591,639)	17
18	Directors Fees													18
19	Professional Services			37,501	33,126	8,187							78,814	19
20	Fees, Subscriptions & Promotions	(44,959)		2,152	11,323	170							(31,314)	20
21	Clerical & General Office Expenses	(15,489)		23,715	140,816	69,400							218,442	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			15,464	949	199							16,612	24
25	Other Admin. Staff Transportation			5,295	2,561	1,715							9,571	25
26	Insurance-Prop.Liab.Malpractice			23,874	631	377							24,882	26
27	Other (specify):*	(532)		55,207	25,760	27,185							107,620	27
28	TOTAL General Administration	(60,980)		(96,421)	(9,309)	(302)							(167,012)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(88,040)		(78,892)	(9,121)	(302)							(176,355)	29

STATE OF ILLINOIS

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning:

07/01/05 Ending:

Summary B

06/30/06

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	6,196		31,394	5,986	110							43,686	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(233)		11,490									11,257	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			36,085	1,525								37,610	34
35	Rent-Equipment & Vehicles			1,010	1,295	193							2,498	35
36	Other (specify):*													36
37	TOTAL Ownership	5,963		79,979	8,806	303							95,051	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	(5,595)											(5,595)	42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(5,595)											(5,595)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(87,672)		1,087	(315)	1							(86,899)	45

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning:

07/01/05

Ending:

06/30/06

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		P.A. Peterson	Rockford, IL	Vesper Mgmt Corp	DesPlaines, IL	Management Co.
				LSSI	DesPlaines, 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 NO

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

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

* 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: 07/01/05 Ending: 06/30/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Management Allocation	558,733	Lutheran Social Services of Illinois - Management Allocation	100.00%		(558,733)	15
16	V	17 Salaries & Wages		Lutheran Social Services of Illinois - Management Allocation	100.00%	299,104	299,104	16
17	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	55,245	55,245	17
18	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	37,501	37,501	18
19	V	21 Supplies, Telephone, Postage, Print		Lutheran Social Services of Illinois - Management Allocation	100.00%	23,001	23,001	19
20	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	36,085	36,085	20
21	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,342	2,342	21
22	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	301	301	22
23	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	11,490	11,490	23
24	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%			24
25	V	26 Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	23,874	23,874	25
26	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%	(38)	(38)	26
27	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	5,295	5,295	27
28	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	80	80	28
29	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	15,464	15,464	29
30	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,152	2,152	30
31	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%	336	336	31
32	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			32
33	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	930	930	33
34	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	13,154	13,154	34
35	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%			35
36	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,396	1,396	36
37	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	714	714	37
38	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	31,394	31,394	38
39	Total		\$ 558,733			\$ 559,820	\$ * 1,087	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# 0013896Report Period Beginning: 07/01/05Ending: 06/30/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 Human Resource Allocation	224,475	Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%		(224,475)	15	
16	V	21 Salaries & Wages		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	132,341	132,341	16	
17	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	25,760	25,760	17	
18	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	33,126	33,126	18	
19	V	21 Supplies, Telephone, Postage, Print		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	8,244	8,244	19	
20	V	34 Rental of Space		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	1,525	1,525	20	
21	V	5 Utilities		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	28	28	21	
22	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%			22	
23	V	32 Interest		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%			23	
24	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%			24	
25	V	26 Insurance		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	631	631	25	
26	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%			26	
27	V	25 Transportation		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	2,561	2,561	27	
28	V	35 Car Rental		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	260	260	28	
29	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	949	949	29	
30	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	1,011	1,011	30	
31	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	79	79	31	
32	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%			32	
33	V	35 Equipment Rental		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	1,035	1,035	33	
34	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	74	74	34	
35	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	10,312	10,312	35	
36	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	7	7	36	
37	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	231	231	37	
38	V	30 Depreciation		Lutheran Social Services of Illinois - Human Resources Alloc.	100.00%	5,986	5,986	38	
39	Total		\$ 224,475			\$ 224,160	\$ *	(315)	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# 0013896Report Period Beginning: 07/01/05Ending: 06/30/06

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Network Administration	107,535	Lutheran Social Services of Illinois - Network Administration	100.00%		(107,535)	15
16	V	21 Salaries & Wages		Lutheran Social Services of Illinois - Network Administration	100.00%	64,154	64,154	16
17	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%	26,615	26,615	17
18	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Network Administration	100.00%	8,187	8,187	18
19	V	21 Supplies, Telephone, Postage, Print		Lutheran Social Services of Illinois - Network Administration	100.00%	5,242	5,242	19
20	V	34 Rental of Space		Lutheran Social Services of Illinois - Network Administration	100.00%			20
21	V	5 Utilities		Lutheran Social Services of Illinois - Network Administration	100.00%			21
22	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Network Administration	100.00%			22
23	V	32 Interest		Lutheran Social Services of Illinois - Network Administration	100.00%			23
24	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Network Administration	100.00%			24
25	V	26 Insurance		Lutheran Social Services of Illinois - Network Administration	100.00%	377	377	25
26	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Network Administration	100.00%	570	570	26
27	V	25 Transportation		Lutheran Social Services of Illinois - Network Administration	100.00%	1,715	1,715	27
28	V	35 Car Rental		Lutheran Social Services of Illinois - Network Administration	100.00%	27	27	28
29	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Network Administration	100.00%	199	199	29
30	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Network Administration	100.00%	170	170	30
31	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Network Administration	100.00%			31
32	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Network Administration	100.00%			32
33	V	35 Equipment Rental		Lutheran Social Services of Illinois - Network Administration	100.00%	166	166	33
34	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Network Administration	100.00%			34
35	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Network Administration	100.00%			35
36	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Network Administration	100.00%			36
37	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Network Administration	100.00%	4	4	37
38	V	30 Depreciation		Lutheran Social Services of Illinois - Network Administration		110	110	38
39	Total		\$ 107,535			\$ 107,536	\$ *	1 39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$		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: 07/01/05 Ending: 06/30/06

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	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/05

Ending: 06/30/06

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

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					\$	\$		\$	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: 07/01/05

Ending: 06/30/06

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 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	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	32,568,454	224	2,973,157	2,973,157	3,276,435	299,104	1
2	27	Empl Benefits & Taxes	32,568,454	224	549,142		3,276,435	55,245	2
3	19	Prof Fees & Contracts	32,568,454	224	372,765		3,276,435	37,501	3
4	21	Supplies, Telephone, Postage, Out. Printing	32,568,454	224	228,636		3,276,435	23,001	4
5	34	Rental of Space	32,568,454	224	358,692		3,276,435	36,085	6
7	5	Utilities	32,568,454	224	23,282		3,276,435	2,342	7
8	6	Bldg Repairs & Maintenance	32,568,454	224	2,989		3,276,435	301	8
9	32	Interest	32,568,454	224	114,210		3,276,435	11,490	9
10	33	Real Estate Taxes	32,568,454	224			3,276,435		10
11	26	Insurance	32,568,454	224	237,309		3,276,435	23,874	11
12	27	Advertising & Promotions	32,568,454	224	(379)		3,276,435	(38)	12
13	25	Transportation	32,568,454	224	52,634		3,276,435	5,295	13
14	35	Car Rental	32,568,454	224	793		3,276,435	80	14
15	24	Conferences & Conventions	32,568,454	224	153,711		3,276,435	15,464	15
16	20	Subscriptions, Dues, Awards	32,568,454	224	21,393		3,276,435	2,152	16
17	6	Furniture & Fixtures	32,568,454	224	3,344		3,276,435	336	17
18	6	Machinery & Equipment	32,568,454	224			3,276,435		18
19	35	Equipment Rental	32,568,454	224	9,241		3,276,435	930	19
20	6	Equipment Repair & Maint.	32,568,454	224	130,757		3,276,435	13,154	20
21	20	Employee Recruitment	32,568,454	224			3,276,435		21
22	7	Security & Waste Removal	32,568,454	224	13,877		3,276,435	1,396	22
23	21	All Other Miscellaneous	32,568,454	224	7,098		3,276,435	714	23
24	30	Depreciation	32,568,454	224	312,062		3,276,435	31,394	24
25	TOTALS				\$ 5,564,713	\$ 2,973,157		\$ 559,820	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/05

Ending: 06/30/06

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Salaries & Wages	52,461,326	218	1,105,382	1,105,382	6,280,913	132,341	1
2	27	Empl Benefits & Taxes	52,461,326	218	215,157		6,280,913	25,760	2
3	19	Prof Fees & Contracts	52,461,326	218	276,688		6,280,913	33,126	3
4	21	Supplies, Telephone,	52,461,326	218			6,280,913		4
5		Postage, Out. Printing	52,461,326	218	68,860		6,280,913	8,244	5
6	34	Rental of Space	52,461,326	218	12,735		6,280,913	1,525	6
7	5	Utilities	52,461,326	218	233		6,280,913	28	7
8	6	Bldg Repairs & Maintenance	52,461,326	218			6,280,913		8
9	32	Interest	52,461,326	218			6,280,913		9
10	33	Real Estate Taxes	52,461,326	218			6,280,913		10
11	26	Insurance	52,461,326	218	5,274		6,280,913	631	11
12	27	Advertising & Promotions	52,461,326	218			6,280,913		12
13	25	Transportation	52,461,326	218	21,388		6,280,913	2,561	13
14	35	Car Rental	52,461,326	218	2,173		6,280,913	260	14
15	24	Conferences & Conventions	52,461,326	218	7,926		6,280,913	949	15
16	20	Subscriptions, Dues, Awards	52,461,326	218	8,446		6,280,913	1,011	16
17	6	Furniture & Fixtures	52,461,326	218	661		6,280,913	79	17
18	6	Machinery & Equipment	52,461,326	218			6,280,913		18
19	35	Equipment Rental	52,461,326	218	8,648		6,280,913	1,035	19
20	6	Equipment Repair & Maint.	52,461,326	218	620		6,280,913	74	20
21	20	Employee Recruitment	52,461,326	218	86,128		6,280,913	10,312	21
22	7	Security & Waste Removal	52,461,326	218	60		6,280,913	7	22
23	21	All Other Miscellaneous	52,461,326	218	1,927		6,280,913	231	23
24	30	Depreciation	52,461,326	218	49,999		6,280,913	5,986	24
25	TOTALS				\$ 1,872,305	\$ 1,105,382		\$ 224,160	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

Report Period Beginning:

07/01/05Ending: 06/30/06

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	21	Salaries & Wages	7,460,771	2	146,085	146,085	3,276,435	64,154	1
2	27	Empl Benefits & Taxes	7,460,771	2	60,605		3,276,435	26,615	2
3	19	Prof Fees & Contracts	7,460,771	2	18,643		3,276,435	8,187	3
4	21	Supplies, Telephone,	7,460,771	2	11,937		3,276,435	5,242	4
5		Postage, Out. Printing	7,460,771	2			3,276,435		5
6	34	Rental of Space	7,460,771	2			3,276,435		6
7	5	Utilities	7,460,771	2			3,276,435		7
8	6	Bldg Repairs & Maintenance	7,460,771	2			3,276,435		8
9	32	Interest	7,460,771	2			3,276,435		9
10	33	Real Estate Taxes	7,460,771	2			3,276,435		10
11	26	Insurance	7,460,771	2	859		3,276,435	377	11
12	27	Advertising & Promotions	7,460,771	2	1,298		3,276,435	570	12
13	25	Transportation	7,460,771	2	3,905		3,276,435	1,715	13
14	35	Car Rental	7,460,771	2	61		3,276,435	27	14
15	24	Conferences & Conventions	7,460,771	2	453		3,276,435	199	15
16	20	Subscriptions, Dues, Awards	7,460,771	2	386		3,276,435	170	16
17	6	Furniture & Fixtures	7,460,771	2			3,276,435		17
18	6	Machinery & Equipment	7,460,771	2			3,276,435		18
19	35	Equipment Rental	7,460,771	2	378		3,276,435	166	19
20	6	Equipment Repair & Maint.	7,460,771	2			3,276,435		20
21	20	Employee Recruitment	7,460,771	2			3,276,435		21
22	7	Security & Waste Removal	7,460,771	2			3,276,435		22
23	21	All Other Miscellaneous	7,460,771	2	8		3,276,435	4	23
24	30	Depreciation	7,460,771	2	250		3,276,435	110	24
25	TOTALS				\$ 244,868	\$ 146,085		\$ 107,536	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/05

Ending: 06/30/06

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	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					\$	\$		\$	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: 07/01/05

Ending: 06/30/06

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	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					\$	\$		\$	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: 07/01/05

Ending: 06/30/06

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	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					\$	\$		\$	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: 07/01/05

Ending: 06/30/06

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	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					\$	\$		\$	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: 07/01/05

Ending: 06/30/06

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	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					\$	\$		\$	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: 07/01/05

Ending: 06/30/06

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	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					\$	\$		\$	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

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 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1	Tax Exempt Bonds		X	Refinance Bldg Additions	N/A	9/23/93	\$ 1,286,188	\$	2/16/06	0.0738	\$ 102,162	1
2	Tax Exempt Bonds		X	Refinance 1993 Bonds	N/A	2/16/06	3,752,000	3,752,000	2028		62,695	2
3												3
4												4
5	See Supplemental Schedule											5
Working Capital												
6	Allocation from LSSI		X								11,490	6
7												7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						\$ 5,038,188	\$ 3,752,000			\$ 176,347	9
B. Non-Facility Related*												
10	Interest Income		X								(233)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			(233)	14
15	TOTALS (line 9+line14)						\$ 5,038,188	\$ 3,752,000			\$ 176,114	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.)

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.)

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

2000 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 2000 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 2000.

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

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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number St Matthew Center for Health

0013896 Report Period Beginning:

07/01/05 Ending:

06/30/06

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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

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	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>	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:

07/01/05

Ending:

06/30/06

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	166		1959	1959	\$ 444,500	\$	40	\$	\$	\$ 444,500	4
5			1966	1966	315,066		40	4,228	4,228	315,066	5
6			1976	1976	2,205,040		40	55,126	55,126	1,680,900	6
7			1976	1976	24,547		40	614	614	18,424	7
8			1977	1977	13,438		40	336	336	9,908	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	11,671	11,671	258,831	15
16	Various			1988	14,914		20			14,914	16
17	Various			1989	253,333		20			253,333	17
18	Various			1990	19,450		20			19,450	18
19	Various			1992	130,569		20	1,229	1,229	117,682	19
20	Various			1993	447,399		20			447,399	20
21	Various			1994	82,338		20			82,338	21
22	Various			1995	38,246		20	249	249	38,246	22
23	Various			1996	5,548		20	258	258	5,548	23
24	Various			1997	23,913		20	2,097	2,097	19,920	24
25	Various			1998	249,986		20	14,755	14,755	113,960	25
26	Various			1999	143,792		20	14,353	14,353	103,234	26
27	Various			2000	114,304		20	11,430	11,430	71,896	27
28	Various			2001	1,626,561		20	106,713	106,713	624,932	28
29	Various			2002	112,800		20	11,280	11,280	47,130	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 6,738,244	\$ 430,317		\$ 234,339	\$ (195,978)	\$ 4,868,323	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:

07/01/05

Ending:

06/30/06

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	Totals from Page 12A, Carried Forward		\$ 6,738,244	\$ 430,317		\$ 234,339	\$ (195,978)	\$ 4,868,323	1
2	<u>Tuckpointing</u>	2003	8,555		20	856	856	2,746	2
3	<u>Masonry Restoration</u>	2003	47,520		20	4,752	4,752	14,456	3
4	<u>Parking Lot Improvements</u>	2003	7,725		20	773	773	2,351	4
5	<u>Landscaping Phase 1</u>	2003	10,780		20	1,078	1,078	3,191	5
6	<u>Landscaping Phase 1</u>	2003	10,780		20	1,078	1,078	3,191	6
7	<u>Window Repairs</u>	2003	2,450		20	245	245	725	7
8	<u>Court Yard Concrete Repairs</u>	2004	7,676		20	768	768	1,567	8
9	<u>Window Repairs From Building Shifting</u>	2004	7,160		20	716	716	1,461	9
10	<u>Window Replacement</u>	2004	5,648		20	565	565	1,156	10
11	<u>Remodeling Of Main & Small Dining Room</u>	2004	52,000		20	2,080	2,080	4,244	11
12	<u>Remodeling Of Main & Small Dining Rooms</u>	2004	3,804		20	152	152	310	12
13	<u>Seal And Restripe Parking Lot</u>	2004	23,565		20	1,465	1,465	2,930	13
14	<u>Court Yard Concrete Repairs</u>	2005	7,676		20	768	768	1,536	14
15	<u>Window Replacement</u>	2005	8,472		20	847	847	1,694	15
16	<u>Fitness Center & Computer Rm/Juice Bar</u>	2005	15,099		20	604	604	781	16
17	<u>Fitness Center & Computer Rm/Juice Bar</u>	2005	11,746		20	470	470	608	17
18	<u>Fitness Center & Computer Rm</u>	2005	5,650		20	226	226	292	18
19	<u>Fitness Center & Computer Rm</u>	2005	64,645		20	2,586	2,586	2,692	19
20	<u>Common Areas Decorating</u>	2005	7,900		20	1,580	1,580	1,645	20
21	<u>Exhaust Hood Replacement</u>	2005	728		20	36	36	36	21
22	<u>Door Replacements</u>	2005	2,335		20	117	117	117	22
23	<u>Door Replacements</u>	2005	2,149		20	107	107	107	23
24	<u>Exhaust Hood Replacement</u>	2005	23,425		20	1,171	1,171	1,171	24
25	<u>Roof Replacement West</u>	2005	1,585		20	79	79	79	25
26	<u>St. Matthew Roof Replacement - West</u>	2005	92,500		20	4,625	4,625	4,625	26
27	<u>St. Matthews Tuckpointing Phase Iii</u>	2005	74,290		20	3,715	3,715	3,715	27
28	<u>Fitness Center & Comp Room/Juicebar</u>	2005	3,402		20	170	170	170	28
29	<u>Roof Replacement</u>	2005	2,700		20	135	135	135	29
30	<u>Window Replacement-Western Ave.</u>	2005	31,210		20	1,561	1,561	1,561	30
31	<u>Roof Replacement-West</u>	2005	89,900		20	4,495	4,495	4,495	31
32	<u>Landscaping</u>	2005	49,993		20	2,500	2,500	2,500	32
33	<u>Roof Replacement-West</u>	2005	1,200		20	60	60	60	33
34	TOTAL (lines 1 thru 33)		\$ 7,422,512	\$ 430,317		\$ 274,718	\$ (155,599)	\$ 4,934,669	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:

07/01/05

Ending:

06/30/06

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	Totals from Page 12B, Carried Forward		\$ 7,422,512	\$ 430,317		\$ 274,718	\$ (155,599)	\$ 4,934,669	1
2	Roof Replacement-West	2005	9,600		20	480	480	480	2
3	Roof Replacement-West	2005	3,474		20	174	174	174	3
4	Parking Lot Phase II	2005	20,935		20	1,047	1,047	1,047	4
5	Removal Of Trees From Courtyards	2005	4,000		20	200	200	200	5
6	Repair Sewer Line	2005	5,475		20	274	274	274	6
7	Apply Fire-Proof Coating And Varnish	2005	7,200		20	360	360	360	7
8	Carpeting	2006	4,336		20	217	217	217	8
9	Courtyard Renovations-Electrical	2006	3,074		20	154	154	154	9
10	Handicap Accessible Doors For Courtyard	2006	6,210		20	311	311	311	10
11	Landscaping	2006	30,000		20	1,500	1,500	1,500	11
12	Roof Replacement West	2006	1,545		20	77	77	77	12
13	Landscaping	2006	295		20	15	15	15	13
14	Landscaping	2006	375		20	19	19	19	14
15	Landscaping	2006	3,000		20	150	150	150	15
16	Landscaping	2006	49,993		20	2,500	2,500	2,500	16
17	Landscaping	2006	22,763		20	1,138	1,138	1,138	17
18	Repair Ejector Pump	2006	2,940		20	147	147	147	18
19	Replace Controller	2006	2,582		20	129	129	129	19
20									20
21									21
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1
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33								33
34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1
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34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1
2								2
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34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1
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33								33
34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Totals from Page 12G, Carried Forward	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1	
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33									33
34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1
2								2
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34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34

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Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1
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34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Totals from Page 12J, Carried Forward	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1	
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33									33
34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Totals from Page 12K, Carried Forward	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1	
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33									33
34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1
2								2
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34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1
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34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34

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Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning:

07/01/05

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06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1
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34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Totals from Page 12O, Carried Forward	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1	
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33									33
34	TOTAL (lines 1 thru 33)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	34	

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	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	Totals from Page 12P, Carried Forward	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	1	
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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)	\$ 7,600,308	\$ 430,317		\$ 283,608	\$ (146,709)	\$ 4,943,559	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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF 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					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
Improvement Type**											
9		Allocation from LSSI				37,490			(37,490)		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

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:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$ 37,490		\$	\$ (37,490)	\$	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: 07/01/05 Ending: 06/30/06

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	\$ 1,805,656	\$	\$ 160,500	\$ 160,500	10	\$ 1,039,967	71
72	Current Year Purchases	27,754		2,775	2,775	10	2,775	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,833,410	\$	\$ 163,275	\$ 163,275		\$ 1,042,742	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		1997 Champion Challenger	1997	\$ 54,610	\$	\$	\$	5	\$ 54,610	76
77										77
78										78
79										79
80	TOTALS			\$ 54,610	\$	\$	\$		\$ 54,610	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)	\$ 9,527,032	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 430,317	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 446,883	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,566	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,040,911	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	9,739	87
88	Bus	46,598	6,657	10,793	88
89					89
90					90
91	TOTALS	\$ 109,442	\$ 10,370	\$ 57,382	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		\$	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/05

Ending: 06/30/06

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6	Allocation from LSSI				37,610			6
7	TOTAL				\$ 37,610			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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 3,988 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 from LSSI		\$ _____	\$ 367	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ 367	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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input 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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 208,424	\$		\$ 208,424	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			86,812			86,812	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			364,331			364,331	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				381,553		381,553	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>See Supplemental</u>					16,864	157,658		174,522	13
14	TOTAL			\$		\$ 676,431	\$ 539,211		\$ 1,215,642	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/05

Ending:

06/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/06

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	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	2	
		Operating	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.)

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# 0013896Report Period Beginning: 07/01/05Ending: 06/30/06**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,065,435	1
2	Discounts and Allowances for all Levels	(281,407)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,784,028	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	237,130	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 237,130	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	1,328	13
14	Non-Patient Meals	3,928	14
15	Telephone, Television and Radio	2,471	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	272,776	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 280,503	23
D. Non-Operating Revenue			
24	Contributions	36,489	24
25	Interest and Other Investment Income***	658	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37,147	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	26,907	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 26,907	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,365,715	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,737,800	31
32	Health Care	4,298,255	32
33	General Administration	3,098,190	33
B. Capital Expense			
34	Ownership	599,389	34
C. Ancillary Expense			
35	Special Cost Centers	1,215,642	35
36	Provider Participation Fee	97,200	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,046,476	40
41	Income before Income Taxes (line 30 minus line 40)**	(680,761)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (680,761)	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: 07/01/05

Ending:

06/30/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,701	4,073	\$ 115,261	\$ 28.30	1
2	Assistant Director of Nursing	1,874	2,008	68,632	34.18	2
3	Registered Nurses	52,995	58,017	1,657,305	28.57	3
4	Licensed Practical Nurses	29,745	33,688	512,504	15.21	4
5	CNAs & Orderlies	112,348	120,603	1,303,265	10.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,444	4,836	46,188	9.55	8
9	Activity Director	4,712	5,317	96,407	18.13	9
10	Activity Assistants					10
11	Social Service Workers	7,116	7,869	119,090	15.13	11
12	Dietician					12
13	Food Service Supervisor	3,721	4,312	56,803	13.17	13
14	Head Cook	5,873	6,451	61,531	9.54	14
15	Cook Helpers/Assistants	26,695	28,165	227,724	8.09	15
16	Dishwashers					16
17	Maintenance Workers	9,658	10,908	182,450	16.73	17
18	Housekeepers	15,948	17,394	136,557	7.85	18
19	Laundry	4,548	5,179	50,082	9.67	19
20	Administrator	1,650	1,800	70,717	39.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,853	7,563	97,573	12.90	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	7,878	8,435	95,787	11.36	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,910	2,083	49,275	23.66	33
34	TOTAL (lines 1 - 33)	300,669	328,701	\$ 4,947,151 *	\$ 15.05	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	\$ 137,867	01-03	35
36	Medical Director	As Needed	52,600	09-03	36
37	Medical Records Consultant	As Needed	3,450	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	352	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	1,354	11-03	44
45	Social Service Consultant	As Needed	1,140	12-03	45
46	Other(specify) <u>Chaplain</u>	As Needed	47,544	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 244,307		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	Amount of Expense Amortized Per Year								
					5 FY2003	6 FY2004	7 FY2005	8 FY2006	9 FY2007	10 FY2008	11 FY2009	12 FY2010	13 FY2011
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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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 \$6,967
- (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. \$ 61,406 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. \$ 91,605
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. \$ 3,928
- (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: 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? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

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