

Facility Name & ID Number St Matthew Center for Health

0013896 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 08/19/07

	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	119	Skilled (SNF)	101	37,848	1
2		Skilled Pediatric (SNF/PED)			2
3	47	Intermediate (ICF)	39	14,666	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	166	TOTALS	140	52,514	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		23,370	8,042	31,412	8
9	SNF/PED					9
10	ICF	14,853			14,853	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,853	23,370	8,042	46,265	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.10%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

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

YES NO

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 43 and days of care provided 6,838

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 6/30/08 Fiscal Year: 6/30/08

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	392,117	35,839	165,873	593,829		593,829		593,829		1
2	Food Purchase		291,218		291,218		291,218	(713)	290,505		2
3	Housekeeping	139,000	46,394		185,394		185,394		185,394		3
4	Laundry	36,260	8,230	167,545	212,035		212,035		212,035		4
5	Heat and Other Utilities			225,558	225,558		225,558	1,533	227,091		5
6	Maintenance	146,324	14,378	199,748	360,450		360,450	(38,809)	321,641		6
7	Other (specify):*							1,251	1,251		7
8	TOTAL General Services	713,701	396,059	758,724	1,868,484		1,868,484	(36,738)	1,831,746		8
	B. Health Care and Programs										
9	Medical Director			82,800	82,800		82,800		82,800		9
10	Nursing and Medical Records	3,619,706	105,841	36,102	3,761,649		3,761,649	(5,754)	3,755,895		10
10a	Therapy										10a
11	Activities	121,642	12,112	1,938	135,692		135,692		135,692		11
12	Social Services	152,998		35,054	188,052		188,052		188,052		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,894,346	117,953	155,894	4,168,193		4,168,193	(5,754)	4,162,439		16
	C. General Administration										
17	Administrative	75,109			75,109		75,109	660,500	735,609		17
18	Directors Fees										18
19	Professional Services			1,208,899	1,208,899		1,208,899	(1,055,959)	152,940		19
20	Dues, Fees, Subscriptions & Promotions			55,280	55,280		55,280	(20,051)	35,229		20
21	Clerical & General Office Expenses	232,514	83,083	92,818	408,415		408,415	43,936	452,351		21
22	Employee Benefits & Payroll Taxes			1,215,748	1,215,748		1,215,748		1,215,748		22
23	Inservice Training & Education										23
24	Travel and Seminar			24,631	24,631		24,631	9,954	34,585		24
25	Other Admin. Staff Transportation			7,939	7,939		7,939	14,424	22,363		25
26	Insurance-Prop.Liab.Malpractice			286,691	286,691		286,691	12,614	299,305		26
27	Other (specify):*							143,944	143,944		27
28	TOTAL General Administration	307,623	83,083	2,892,006	3,282,712		3,282,712	(190,639)	3,092,073		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,915,670	597,095	3,806,624	9,319,389		9,319,389	(233,131)	9,086,258		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: 07/01/07 Ending: 06/30/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			459,779	459,779		459,779	(11,244)	448,535			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,658	171,658		171,658	14,271	185,929			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							39,063	39,063			34
35	Rent-Equipment & Vehicles							3,706	3,706			35
36	Other (specify):*			25,834	25,834		25,834		25,834			36
37	TOTAL Ownership			657,271	657,271		657,271	45,796	703,067			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		424,184	584,199	1,008,383		1,008,383		1,008,383			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,908	76,908		76,908	1,863	78,771			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		424,184	661,107	1,085,291		1,085,291	1,863	1,087,154			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,915,670	1,021,279	5,125,002	11,061,951		11,061,951	(185,472)	10,876,479			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: 07/01/07

Ending: 06/30/08

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(713)	02		4
5	Telephone, TV & Radio in Resident Rooms	(6,571)	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	(58,255)	30		9
10	Interest and Other Investment Income	(656)	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	(44,185)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(75,092)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (185,472)		\$	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)	(0)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (0)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (185,472)		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.

		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						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

St Matthew Center for Health

ID# 0013896

Report Period Beginning: 07/01/07

Ending: 06/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Finance Charge	\$ (338)	21	1
2	Sales to Public	(611)	21	2
3	Clothing & Personal Supplies	(5,754)	10	3
4	Misc. Inc.	(2,097)	21	4
5	Collection Fees	(5,606)	21	5
6	Bed Tax	1,863	42	6
7	Capitalized R&Ms	(51,585)	06	7
8	Gain on Sale of Fixed Assets	(600)	30	8
9	Non-Care Depreciation	(10,364)	30	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(75,092)		49

St Matthew Center for Health

ID# 0013896

Report Period Beginning: 07/01/07

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Sch. V Line

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	(713)											(713)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,229	35	51	176	43					1,533	5
6	Maintenance	(51,585)		10,377	1,926	268	169	36					(38,809)	6
7	Other (specify):*			1,213	6	3	27	2					1,251	7
8	TOTAL General Services	(52,298)		12,818	1,967	322	371	81					(36,738)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(5,754)											(5,754)	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	(5,754)											(5,754)	16
	C. General Administration													
17	Administrative			273,465	105,779	108,699	122,657	49,901					660,500	17
18	Directors Fees													18
19	Professional Services			(474,135)	(170,430)	(153,570)	(175,913)	(81,911)					(1,055,959)	19
20	Fees, Subscriptions & Promotions	(44,185)		11,771	11,093		1,072	199					(20,051)	20
21	Clerical & General Office Expenses	(15,223)		20,976	4,464	1,653	19,246	12,819					43,936	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			4,973	3,727	466	731	57					9,954	24
25	Other Admin. Staff Transportation			4,097	1,268	5,225	2,855	978					14,424	25
26	Insurance-Prop.Liab.Malpractice			11,480	287	441	360	45					12,614	26
27	Other (specify):*			58,979	25,984	22,736	19,261	16,984					143,944	27
28	TOTAL General Administration	(59,408)		(88,393)	(17,828)	(14,350)	(9,731)	(929)					(190,639)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(117,460)		(75,574)	(15,861)	(14,028)	(9,360)	(848)					(233,131)	29

STATE OF ILLINOIS

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning:

07/01/07

Ending:

Summary B

06/30/08

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(69,219)		39,804	11,194	1,247	5,273	458					(11,244)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(656)		7,811	1,255	5,150	711						14,271	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			26,653	2,289	7,461	2,660						39,063	34
35	Rent-Equipment & Vehicles			1,306	1,124	171	716	390					3,706	35
36	Other (specify):*													36
37	TOTAL Ownership	(69,875)		75,574	15,861	14,028	9,360	848					45,796	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	1,863											1,863	42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	1,863											1,863	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(185,472)				(0)	(0)	(0)					(185,472)	45

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning:

07/01/07

Ending:

06/30/08

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	Des Plaines, IL	Management Co.
				LSSI	Des Plaines, IL	Corporate Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES 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		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Salaries & Wages	\$	Lutheran Social Services of Illinois - Management Allocation	100.00%	\$ 273,465	\$ 273,465	15
16	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	58,979	58,979	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	42,602	42,602	17
18	V	21 Supplies, Telephone, Postage, Printing		Lutheran Social Services of Illinois - Management Allocation	100.00%	19,555	19,555	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	26,653	26,653	19
20	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,229	1,229	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	491	491	21
22	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	7,811	7,811	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%			23
24	V	26 Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	11,480	11,480	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%			25
26	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	4,097	4,097	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	248	248	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	4,973	4,973	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,897	1,897	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%	0	0	30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,058	1,058	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	9,886	9,886	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%	9,873	9,873	34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,213	1,213	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,421	1,421	36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	39,804	39,804	37
38	V	19 Management Allocation	516,737	Lutheran Social Services of Illinois - Management Allocation	100.00%		(516,737)	38
39	Total		\$ 516,737			\$ 516,737	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 Salaries & Wages	\$	Lutheran Social Services of Illinois - Management Allocation	100.00%	\$ 105,779	\$ 105,779	15
16	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	25,984	25,984	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	37,026	37,026	17
18	V	21 Supplies, Telephone, Postage, Printing		Lutheran Social Services of Illinois - Management Allocation	100.00%	4,283	4,283	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,289	2,289	19
20	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	35	35	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%			21
22	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,255	1,255	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%			23
24	V	26 Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	287	287	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%			25
26	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,268	1,268	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	154	154	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	3,727	3,727	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	303	303	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%			30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	970	970	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,926	1,926	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%	10,790	10,790	34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	6	6	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	181	181	36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	11,194	11,194	37
38	V	19 Human Resource Allocation	207,456	Lutheran Social Services of Illinois - Management Allocation	100.00%		(207,456)	38
39	Total		\$ 207,456			\$ 207,456	\$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/07 Ending: 06/30/08

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 Salaries & Wages	\$	Lutheran Social Services of Illinois - Management Allocation	100.00%	\$ 108,699	\$ 108,699	15
16	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	22,736	22,736	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	327	327	17
18	V	21 Supplies, Telephone, Postage, Printing		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,653	1,653	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	7,461	7,461	19
20	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	51	51	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	24	24	21
22	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	5,150	5,150	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%			23
24	V	26 Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	441	441	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%			25
26	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	5,225	5,225	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	1	1	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	466	466	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%			29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%	8	8	30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	170	170	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	237	237	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%			34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	3	3	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%			36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,247	1,247	37
38	V	19 Service Network Allocation	153,897	Lutheran Social Services of Illinois - Management Allocation	100.00%		(153,897)	38
39	Total		\$ 153,897			\$ 153,897	\$ *	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: 07/01/07Ending: 06/30/08

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 Salaries & Wages	\$	Lutheran Social Services of Illinois - Management Allocation	100.00%	\$ 122,657	\$ 122,657	15
16	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	19,261	19,261	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	14,831	14,831	17
18	V	21 Supplies, Telephone, Postage, Printing		Lutheran Social Services of Illinois - Management Allocation	100.00%	18,169	18,169	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,660	2,660	19
20	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	176	176	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	35	35	21
22	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	711	711	22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%			23
24	V	26 Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	360	360	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%			25
26	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,855	2,855	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	201	201	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	731	731	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,072	1,072	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%	1	1	30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	514	514	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	132	132	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%			34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	27	27	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,078	1,078	36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	5,273	5,273	37
38	V	19 Adv / Comm Alloc	190,744	Lutheran Social Services of Illinois - Management Allocation	100.00%		(190,744)	38
39	Total		\$ 190,744			\$ 190,744	\$ *	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: 07/01/07Ending: 06/30/08

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 Salaries & Wages	\$	Lutheran Social Services of Illinois - Management Allocation	100.00%	\$ 49,901	\$ 49,901	15
16	V	27 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	13,913	13,913	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	3,578	3,578	17
18	V	21 Supplies, Telephone, Postage, Printing		Lutheran Social Services of Illinois - Management Allocation	100.00%	12,818	12,818	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%			19
20	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	43	43	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	6	6	21
22	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%			22
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%			23
24	V	26 Insurance		Lutheran Social Services of Illinois - Management Allocation	100.00%	45	45	24
25	V	27 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%	3,071	3,071	25
26	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	978	978	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	243	243	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	57	57	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	199	199	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%	1	1	30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	147	147	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	29	29	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Management Allocation	100.00%			34
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Management Allocation	100.00%	2	2	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	0	0	36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	458	458	37
38	V	19 Adv / Comm Alloc	85,489	Lutheran Social Services of Illinois - Management Allocation	100.00%		(85,489)	38
39	Total		\$ 85,489			\$ 85,489	\$ *	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/07

Ending: 06/30/08

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

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/07

Ending: 06/30/08

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

Facility Name & ID Number St Matthew Center for Health # 0013896 Report Period Beginning: 07/01/07 Ending: 06/30/08

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: 07/01/07

Ending: 06/30/08

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: 07/01/07

Ending: 06/30/08

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	Non-Capital Direct Costs	274	4,213,692	4,213,692		273,465	1
2	27	Empl Benefits & Taxes		274	908,786			58,979	2
3	19	Prof Fees & Contracts		274	656,431			42,602	3
4	21	Supplies, Telephone,Postage, Printing		274	301,318			19,555	4
5	34	Rental of Space		274	410,691			26,653	5
6	5	Utilities		274	18,931			1,229	6
7	6	Bldg Repairs & Maintenance		274	7,564			491	7
8	32	Interest		274	120,357			7,811	8
9	33	Real Estate Taxes		274					9
10	26	Insurance		274	176,896			11,480	10
11	27	Advertising & Promotions		274					11
12	25	Transportation		274	63,130			4,097	12
13	35	Car Rental		274	3,814			248	13
14	24	Conferences & Conventions		274	76,634			4,973	14
15	20	Subscriptions, Dues, Awards		274	29,236			1,897	15
16	6	Furniture & Fixtures		274	7			0	16
17	6	Machinery & Equipment		274					17
18	35	Equipment Rental		274	16,303			1,058	18
19	6	Equipment Repair & Maint.		274	152,325			9,886	19
20	20	Employee Recruitment		274	152,132			9,873	20
21	7	Security & Waste Removal		274	18,687			1,213	21
22	21	All Other Miscellaneous		274	21,897			1,421	22
23	30	Depreciation		274	613,325			39,804	23
24									24
25	TOTALS				\$ 7,962,156	\$ 4,213,692		\$ 516,737	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/07

Ending: 06/30/08

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	
17	Salaries & Wages	Salaries & Benefits		260	\$ 947,759	\$ 947,759		\$ 105,779	1
27	Empl Benefits & Taxes			260	232,814			25,984	2
19	Prof Fees & Contracts			260	331,748			37,026	3
21	Supplies, Telephone,Postage, Printing			260	38,377			4,283	4
34	Rental of Space			260	20,505			2,289	5
5	Utilities			260	314			35	6
6	Bldg Repairs & Maintenance			260					7
32	Interest			260	11,244			1,255	8
33	Real Estate Taxes			260					9
26	Insurance			260	2,571			287	10
27	Advertising & Promotions			260					11
25	Transportation			260	11,362			1,268	12
35	Car Rental			260	1,377			154	13
24	Conferences & Conventions			260	33,392			3,727	14
20	Subscriptions, Dues, Awards			260	2,715			303	15
6	Furniture & Fixtures			260					16
6	Machinery & Equipment			260					17
35	Equipment Rental			260	8,694			970	18
6	Equipment Repair & Maint.			260	17,260			1,926	19
20	Employee Recruitment			260	96,673			10,790	20
7	Security & Waste Removal			260	53			6	21
21	All Other Miscellaneous			260	1,623			181	22
30	Depreciation			260	100,292			11,194	23
									24
25	TOTALS				\$ 1,858,773	\$ 947,759		\$ 207,456	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/07

Ending: 06/30/08

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	Non-Capital Direct Costs	2	\$ 746,513	\$ 746,513		\$ 108,699	1
2	27	Empl Benefits & Taxes		2	156,141			22,736	2
3	19	Prof Fees & Contracts		2	2,243			327	3
4	21	Supplies, Telephone, Postage, Printing		2	11,350			1,653	4
5	34	Rental of Space		2	51,238			7,461	5
6	5	Utilities		2	352			51	6
7	6	Bldg Repairs & Maintenance		2	162			24	7
8	32	Interest		2	35,369			5,150	8
9	33	Real Estate Taxes		2					9
10	26	Insurance		2	3,032			441	10
11	27	Advertising & Promotions		2					11
12	25	Transportation		2	35,886			5,225	12
13	35	Car Rental		2	4			1	13
14	24	Conferences & Conventions		2	3,202			466	14
15	20	Subscriptions, Dues, Awards		2					15
16	6	Furniture & Fixtures		2	52			8	16
17	6	Machinery & Equipment		2					17
18	35	Equipment Rental		2	1,168			170	18
19	6	Equipment Repair & Maint.		2	1,628			237	19
20	20	Employee Recruitment		2					20
21	7	Security & Waste Removal		2	20			3	21
22	21	All Other Miscellaneous		2					22
23	30	Depreciation		2	8,561			1,247	23
24									24
25	TOTALS				\$ 1,056,921	\$ 746,513		\$ 153,897	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/07

Ending: 06/30/08

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	Non-Capital Direct Costs	103	\$ 1,436,911	\$ 1,436,911		\$ 122,657	1
2	27	Empl Benefits & Taxes		103	225,635			19,261	2
3	19	Prof Fees & Contracts		103	173,743			14,831	3
4	21	Supplies, Telephone,Postage, Printing		103	212,846			18,169	4
5	34	Rental of Space		103	31,165			2,660	5
6	5	Utilities		103	2,056			176	6
7	6	Bldg Repairs & Maintenance		103	409			35	7
8	32	Interest		103	8,331			711	8
9	33	Real Estate Taxes		103					9
10	26	Insurance		103	4,219			360	10
11	27	Advertising & Promotions		103					11
12	25	Transportation		103	33,450			2,855	12
13	35	Car Rental		103	2,359			201	13
14	24	Conferences & Conventions		103	8,563			731	14
15	20	Subscriptions, Dues, Awards		103	12,556			1,072	15
16	6	Furniture & Fixtures		103	14			1	16
17	6	Machinery & Equipment		103					17
18	35	Equipment Rental		103	6,023			514	18
19	6	Equipment Repair & Maint.		103	1,551			132	19
20	20	Employee Recruitment		103					20
21	7	Security & Waste Removal		103	316			27	21
22	21	All Other Miscellaneous		103	12,624			1,078	22
23	30	Depreciation		103	61,768			5,273	23
24									24
25	TOTALS				\$ 2,234,539	\$ 1,436,911		\$ 190,744	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/07

Ending: 06/30/08

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	Non-Capital Direct Costs	104	\$ 348,801	\$ 348,801		\$ 49,901	1
2	27	Empl Benefits & Taxes		104	97,253			13,913	2
3	19	Prof Fees & Contracts		104	25,010			3,578	3
4	21	Supplies, Telephone,Postage, Printing		104	89,599			12,818	4
5	34	Rental of Space		104					5
6	5	Utilities		104	298			43	6
7	6	Bldg Repairs & Maintenance		104	43			6	7
8	32	Interest		104					8
9	33	Real Estate Taxes		104					9
10	26	Insurance		104	317			45	10
11	27	Advertising & Promotions		104	21,465			3,071	11
12	25	Transportation		104	6,835			978	12
13	35	Car Rental		104	1,698			243	13
14	24	Conferences & Conventions		104	395			57	14
15	20	Subscriptions, Dues, Awards		104	1,390			199	15
16	6	Furniture & Fixtures		104	7			1	16
17	6	Machinery & Equipment		104					17
18	35	Equipment Rental		104	1,030			147	18
19	6	Equipment Repair & Maint.		104	201			29	19
20	20	Employee Recruitment		104					20
21	7	Security & Waste Removal		104	17			2	21
22	21	All Other Miscellaneous		104	2			0	22
23	30	Depreciation		104	3,200			458	23
24									24
25	TOTALS				\$ 597,561	\$ 348,801		\$ 85,489	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St Matthew Center for Health

0013896

Report Period Beginning: 07/01/07

Ending: 06/30/08

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: 07/01/07

Ending: 06/30/08

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: 07/01/07

Ending: 06/30/08

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: 07/01/07

Ending: 06/30/08

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	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	Tax Exempt Bonds		X	Refinance Bldg Additions		02/16/2006	\$ 3,752,000	\$ 3,593,478	2/16/2028	0.0523	\$ 171,658	1								
2												2								
3												3								
4												4								
5	See Supplemental Schedule											5								
Working Capital																				
6	Allocation LSSI		X								14,927	6								
7												7								
8	See Supplemental Schedule											8								
9	TOTAL Facility Related						\$ 3,752,000	\$ 3,593,478			\$ 186,585	9								
B. Non-Facility Related*																				
10	Interest Income		X								(656)	10								
11												11								
12												12								
13	See Supplemental Schedule											13								
14	TOTAL Non-Facility Related						\$	\$			\$ (656)	14								
15	TOTALS (line 9+line14)						\$ 3,752,000	\$ 3,593,478			\$ 185,929	15								

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

* 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																				
	Working Capital																				
8						\$	\$			\$	8										
9											9										
10											10										
11											11										
12											12										
13											13										
14	TOTAL Working Capital																				
	B. Non-Facility Related*																				
15						\$	\$			\$	15										
16											16										
17											17										
18											18										
19											19										
20	TOTAL Non-Facility Related																				

* 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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:** 2007 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 2007 real estate tax costs, as well as copies of your real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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	\$ _____	\$ _____

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:

07/01/07 Ending:

06/30/08

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

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			315,066	5
6			1976	1976	2,205,040	55,054	40	55,126	72	1,791,152	6
7			1976	1976	24,547	616	40	614	(2)	19,652	7
8			1977	1977	13,438	336	40	336		10,580	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	282,173	15
16	Various			1988	14,914		20			14,914	16
17	Various			1989	253,333		20			253,333	17
18	Various			1990	20,850		20			19,450	18
19	Various			1992	130,569		20	1,229	1,229	120,140	19
20	Various			1993	453,424		20			453,424	20
21	Various			1994	82,338		20			82,338	21
22	Various			1995	38,246		20			38,246	22
23	Various			1996	5,548		20			5,548	23
24	Various			1997	23,913		20	239	239	21,088	24
25	Various			1998	249,986		20	14,732	14,732	143,447	25
26	Various			1999	140,442		20	13,522	13,522	124,756	26
27	Various			2000	513,756		20	32,731	32,731	266,244	27
28	Various			2001	1,053,653		20	49,619	49,619	381,881	28
29	Various			2002	112,800		20	11,280	11,280	69,690	29
30	Various			2003	87,810		20	8,782	8,782	44,224	30
31	Various			2004	116,001		20	7,361	7,361	29,620	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:

07/01/07

Ending:

06/30/08

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					57,976		(57,976)	68
69					393,409		(393,409)	69
70		\$ 6,772,674	\$ 507,391		\$ 207,242	\$ (300,149)	\$ 5,112,178	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:

07/01/07

Ending:

06/30/08

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		\$ 6,772,674	\$ 507,391		\$ 207,242	\$ (300,149)	\$ 5,112,178	1
2	Fitness Center & Computer Rm/Juice Bar	2005	15,099		20	604	604	1,989	2
3	Fitness Center & Computer Rm/Juice Bar	2005	11,746		20	470	470	1,548	3
4	Fitness Center & Computer Rm	2005	5,650		20	226	226	744	4
5	Fitness Center & Computer Rm	2005	64,645		20	2,586	2,586	7,863	5
6	Common Areas Decorating	2005	7,900		20	1,580	1,580	4,805	6
7	Exhaust Hood Replacement	2005	728		20	36	36	109	7
8	Door Replacements	2005	2,335		20	117	117	350	8
9	Door Replacements	2005	2,149		20	107	107	322	9
10	Exhaust Hood Replacement	2005	23,425		20	1,171	1,171	3,514	10
11	Roof Replacement West	2005	1,585		20	79	79	238	11
12	St. Matthew Roof Replacement - West	2005	92,500		20	4,625	4,625	13,875	12
13	St. Matthews Tuckpointing Phase Iii	2005	74,290		20	3,715	3,715	11,144	13
14	Fitness Center & Comp Room/Juicebar	2005	3,402		20	170	170	510	14
15	Roof Replacement	2005	2,700		20	135	135	405	15
16	Window Replacement-Western Ave.	2005	31,210		20	1,561	1,561	4,682	16
17	Roof Replacement-West	2005	89,900		20	4,495	4,495	13,485	17
18	Landscaping	2005	49,993		20	2,500	2,500	7,499	18
19	Roof Replacement-West	2005	1,200		20	60	60	180	19
20	Roof Replacement-West	2005	9,600		20	480	480	1,440	20
21	Roof Replacement-West	2005	3,474		20	174	174	521	21
22	Parking Lot Phase Ii	2005	20,935		20	1,047	1,047	3,140	22
23	Courtyard Renovations-Electrical	2005	3,074		20	154	154	461	23
24	Handicap Accessible Doors For Courtyard	2005	6,210		20	311	311	932	24
25	Roof Replacement West	2005	1,545		20	77	77	232	25
26	Landscaping	2005	295		20	15	15	44	26
27	Landscaping	2005	375		20	19	19	56	27
28	Landscaping	2005	3,000		20	150	150	450	28
29	Landscaping	2005	49,993		20	2,500	2,500	7,499	29
30	Removal Of Trees From Courtyards	2005	4,000		20	200	200	600	30
31	Repair Sewer Line	2005	5,475		20	274	274	821	31
32	Apply Fire-Proof Coating And Varnish	2005	7,200		20	360	360	1,080	32
33	Carpeting	2006	4,336		20	217	217	650	33
34	TOTAL (lines 1 thru 33)		\$ 7,372,642	\$ 507,391		\$ 237,454	\$ (269,937)	\$ 5,203,366	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:

07/01/07

Ending:

06/30/08

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		\$ 7,372,642	\$ 507,391		\$ 237,454	\$ (269,937)	\$ 5,203,366	1
2	Landscaping	2006	30,000		20	1,500	1,500	4,500	2
3	Landscaping	2006	22,763		20	1,138	1,138	3,414	3
4	Repair Ejector Pump	2006	2,940		20	147	147	441	4
5	Replace Controller	2006	2,582		20	129	129	387	5
6	Fire Alarm Equipment	2006	9,165		20	458	458	917	6
7	Chapel Lane Boiler Room Abatement	2006	3,075		20	154	154	308	7
8	Temp Control	2006	14,650		20	733	733	1,465	8
9	Hot Water Storage Tank	2006	18,900		20	945	945	1,890	9
10	Parking Lot & Front Sidewalk	2006	85,052		20	4,253	4,253	8,505	10
11	Parking Lot Pole Light Relocation	2006	3,490		20	175	175	349	11
12	Pathways Project -Medicare Unit- Bathtubs	2006	21,800		20	1,090	1,090	2,180	12
13	Install 4 New Exit Signes*	2006	2,645		20	132	132	397	13
14	Boilers & Hot Water Storage Tanks	2007	83,498		20	4,175	4,175	8,350	14
15	Insulate Ductwork On Roof	2007	12,100		20	605	605	1,210	15
16	Exterior Door	2007	5,761		20	288	288	576	16
17	Chapel Lane Hot Water Tank Abatement	2007	3,875		20	194	194	388	17
18	Emergency Lighting In Kitchen	2007	3,180		20	159	159	318	18
19	Relocate Alarms & Doorbell	2007	2,180		20	109	109	218	19
20	Pathwys Renovations-Medicare Unit - Carpeting/Flooring	2007	57,042		20	2,852	2,852	5,704	20
21	Laundry Room Door	2007	2,434		20	122	122	243	21
22	Instl. Addtl. Carbon Monoxide Detectors*	2007	5,725		20	286	286	573	22
23	Relocation Of Fire System Annunciator*	2007	1,734		20	87	87	173	23
24	Backflow Device For Sprinkler System*	2007	5,940		20	297	297	594	24
25	Concrete Pad-Smoking Area*	2007	2,285		20	114	114	229	25
26	Painting & Decorating*	2007	3,582		20	179	179	358	26
27	Additional Smoke Detectors	2007	38,248		20	1,912	1,912	1,912	27
28	Exterior Stairwell Door	2007	4,944		20	247	247	247	28
29	Addtl Smoke Detectors/Fire Alarm System	2007	4,250		20	212	212	212	29
30	Condensing Units For East Building	2007	57,398		20	2,870	2,870	2,870	30
31	Irrigation System	2007	37,500		20	1,875	1,875	1,875	31
32	Pathway-Painting, Nursing Stations,Flooring For Medicare Unit	2007	135,684		20	6,784	6,784	6,784	32
33	Pathway-Painting, Nursing Stations,Flooring For Medicare Unit	2007	99,758		20	4,988	4,988	4,988	33
34	TOTAL (lines 1 thru 33)		\$ 8,156,821	\$ 507,391		\$ 276,663	\$ (230,728)	\$ 5,265,941	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	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,156,821	\$ 507,391		\$ 276,663	\$ (230,728)	\$ 5,265,941	1
2	Reconfiguration Of Nurse Call System	2007	3,700		20	185	185	185	2
3	Architect Services-Pathways Renovation	2007	4,495		20	225	225	225	3
4	Canopy Repair	2007	2,785		20	139	139	139	4
5	Insulation Of Piping	2007	7,275		20	364	364	364	5
6	Insulation Of Piping	2007	7,000		20	350	350	350	6
7	Repair Piping	2007	14,300		20	715	715	715	7
8	Window Treatments	2008	19,997		20	1,000	1,000	1,000	8
9	Painting	2008	15,730		20	787	787	787	9
10									10
11									11
12	Gain on sale of fixed assets			(600)			600		12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

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Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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
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20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12K, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

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Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12L, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

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Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12M, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12N, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12O, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12P, Carried Forward		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,232,103	\$ 506,791		\$ 280,427	\$ (226,364)	\$ 5,269,705	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:

07/01/07

Ending:

06/30/08

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:

07/01/07

Ending:

06/30/08

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:

07/01/07

Ending:

06/30/08

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		Allocation from LSSI				57,976			(57,976)		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:

07/01/07

Ending:

06/30/08

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)	\$	\$ 57,976		\$	\$ (57,976)	\$	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: 07/01/07 Ending: 06/30/08

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	\$ 1,647,775	\$	\$ 166,405	\$ 166,405	10	\$ 978,598	71
72	Current Year Purchases	17,045		1,705	1,705	10	1,705	72
73	Fully Depreciated Assets	387,278				10	387,278	73
74								74
75	TOTALS	\$ 2,052,098	\$	\$ 168,109	\$ 168,109		\$ 1,367,580	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)	\$ 10,377,514	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 506,791	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 448,536	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (58,255)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,691,895	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 - 1900	\$ 36,850	\$	\$ 36,850	86
87	Pickup Truck - 1900	25,994	3,710	17,159	87
88	Bus - 1900	46,598	6,654	24,101	88
89					89
90					90
91	TOTALS	\$ 109,442	\$ 10,364	\$ 78,110	91

G. Construction-in-Progress

	Description	Cost	
92	Shower/Bathrm Renovation	\$ 27,713	92
93			93
94			94
95		\$ 27,713	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: 07/01/07

Ending: 06/30/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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	Allocation LSSI				39,063			5
6								6
7	TOTAL				\$ 39,063			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 2,859

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation LSSI		\$	\$ 847	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 847	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	\$		\$ 224,355	\$		\$ 224,355	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			59,133			59,133	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			252,678			252,678	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			6,139			6,139	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				279,906		279,906	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <u>See Supplemental</u>					41,894	144,278		186,172	13
14	TOTAL			\$		\$ 584,199	\$ 424,184		\$ 1,008,383	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# 0013896Report Period Beginning: 07/01/07

Ending:

06/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/08

(last day of reporting year)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

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)	(568,770)	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: 07/01/07Ending: 06/30/08**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	\$ 9,402,374	1
2	Discounts and Allowances for all Levels	(193,990)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,208,384	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	203,616	6
7	Oxygen	15,514	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 219,130	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	1,200	13
14	Non-Patient Meals	713	14
15	Telephone, Television and Radio	6,571	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	162	19
20	Radiology and X-Ray		20
21	Other Medical Services	576,399	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 585,045	23
D. Non-Operating Revenue			
24	Contributions	476,320	24
25	Interest and Other Investment Income***	994	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 477,314	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	3,308	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,308	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,493,181	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,868,484	31
32	Health Care	4,168,193	32
33	General Administration	3,282,712	33
B. Capital Expense			
34	Ownership	657,271	34
C. Ancillary Expense			
35	Special Cost Centers	1,008,383	35
36	Provider Participation Fee	76,908	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,061,951	40
41	Income before Income Taxes (line 30 minus line 40)**	(568,770)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (568,770)	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: 07/01/07

Ending:

06/30/08

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	5,140 #	5,972	\$ 174,574	\$ 29.23	1
2	Assistant Director of Nursing	2,873	3,173	92,749	29.23	2
3	Registered Nurses	46,825	52,166	1,567,929	30.06	3
4	Licensed Practical Nurses	7,157	8,013	200,782	25.06	4
5	CNAs & Orderlies	118,568	132,636	1,562,168	11.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,742	1,957	27,639	14.12	9
10	Activity Assistants	8,393	9,192	94,003	10.23	10
11	Social Service Workers	5,190	5,892	95,352	16.18	11
12	Dietician					12
13	Food Service Supervisor	3,314	3,911	53,210	13.61	13
14	Head Cook	5,529	6,191	63,088	10.19	14
15	Cook Helpers/Assistants	27,555	29,840	275,819	9.24	15
16	Dishwashers					16
17	Maintenance Workers	8,149	9,471	146,324	15.45	17
18	Housekeepers	14,650	15,995	139,000	8.69	18
19	Laundry	3,602	3,937	36,260	9.21	19
20	Administrator	1,545	1,838	75,109	40.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,292	3,695	73,588	19.92	23
24	Clerical	11,036	12,461	158,926	12.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,637	1,929	21,504	11.15	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,695	1,958	57,646	29.44	33
34	TOTAL (lines 1 - 33)	277,892	310,227	\$ 4,915,670 *	\$ 15.85	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	\$ 165,873	01-03	35
36	Medical Director	As Needed	82,800	09-03	36
37	Medical Records Consultant	As Needed	14,700	10-03	37
38	Nurse Consultant	As Needed	20,352	10-03	38
39	Pharmacist Consultant	As Needed	1,051	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	1,938	11-03	44
45	Social Service Consultant	As Needed	256	12-03	45
46	Other(specify) <u>Chaplain</u>	As Needed	34,798	12-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 321,768		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 FY2004	6 FY2005	7 FY2006	8 FY2007	9 FY2008	10 FY2009	11 FY2010	12 FY2011	13 FY2012
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
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13													
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17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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 - \$6,280
- (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? 10Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 50,260 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. \$ 78,771
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. \$ 713
- (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: Virchow Krause & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not Complete
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT