## I. IDPH License ID Number: 0013896

**Facility Name:** St. Matthew Center For Health  
**Address:** 1601 North Western Avenue, Park Ridge 60068  
**County:** Cook  
**Telephone Number:** (847)825-5531  
**Fax:** (847)318-6659  
**HFS ID Number:**  
**Date of Initial License for Current Owners:** 00/00/59  
**Type of Ownership:** Administrator 

### IRS Exemption Code

<table>
<thead>
<tr>
<th>X</th>
<th>VOLUNTARY, NON-PROFIT</th>
<th>PROPRIETARY</th>
<th>GOVERNMENTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Charitable Corp.</td>
<td>Individual</td>
<td>State</td>
</tr>
<tr>
<td>X</td>
<td>Trust</td>
<td>Partnership</td>
<td>County</td>
</tr>
<tr>
<td></td>
<td>&quot;Sub-S&quot; Corp.</td>
<td>Corporation</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Limited Liability Co.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

## II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/10 to 06/30/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

Preparer  
(Signed) ___________________________ (Type or Print Name) ___________________________ (Date) ___________________________  

Paid  
(Firm Name) Frost, Ruttenberg & Rothblatt, P.C.  
& Address) 111 Pfingsten Road, Suite 300 Deerfield, IL 60015  
(Telephone) (847) 236-1111  

See Accountants’ Compilation Report.
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

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

B. Census-For the entire report period.

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>2 Patient Days by Level of Care and Primary Source of Payment</th>
<th>3</th>
<th>4</th>
<th>5 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicaid Recipient</td>
<td>Private Pay</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td>8 SNF</td>
<td>14,780</td>
<td>12,638</td>
<td>9,447</td>
<td>36,865</td>
</tr>
<tr>
<td>9 SNF/PED</td>
<td>9</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>10 ICF</td>
<td>8,057</td>
<td></td>
<td>8,057</td>
<td>10</td>
</tr>
<tr>
<td>11 ICF/DD</td>
<td>11</td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>12 SC</td>
<td>12</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>13 DD 16 OR LESS</td>
<td>13</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>14 TOTALS</td>
<td>14,780</td>
<td>20,695</td>
<td>9,447</td>
<td>44,922</td>
</tr>
</tbody>
</table>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.91%
### V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th>Costs Per General Ledger</th>
<th>Reclassification</th>
<th>Reclassified Total</th>
<th>Adjustments</th>
<th>Adjusted Total</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage</td>
<td>Supplies</td>
<td>Other</td>
<td>Total</td>
<td>Reclassified</td>
<td>Total</td>
</tr>
<tr>
<td>A. General Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Dietary</td>
<td>437,856</td>
<td>38,046</td>
<td>149,068</td>
<td>624,970</td>
<td>624,970</td>
<td>624,970</td>
</tr>
<tr>
<td>3. Housekeeping</td>
<td>171,798</td>
<td>36,277</td>
<td></td>
<td>208,075</td>
<td>208,075</td>
<td>208,075</td>
</tr>
<tr>
<td>4. Laundry</td>
<td>72,437</td>
<td>17,359</td>
<td>13,063</td>
<td>102,859</td>
<td>102,859</td>
<td>102,859</td>
</tr>
<tr>
<td>5. Heat and Other Utilities</td>
<td></td>
<td></td>
<td></td>
<td>217,174</td>
<td>217,174</td>
<td>(12,004)</td>
</tr>
<tr>
<td>7. Other (specify)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,005</td>
</tr>
<tr>
<td>8. TOTAL General Services</td>
<td>823,025</td>
<td>502,885</td>
<td>549,762</td>
<td>1,875,672</td>
<td>1,875,672</td>
<td>1,833,109</td>
</tr>
<tr>
<td>B. Health Care and Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Medical Director</td>
<td></td>
<td></td>
<td></td>
<td>70,400</td>
<td>70,400</td>
<td>70,400</td>
</tr>
<tr>
<td>10. Nursing and Medical Records</td>
<td>3,646,696</td>
<td>103,684</td>
<td>18,416</td>
<td>3,768,796</td>
<td>3,768,796</td>
<td>(19,699)</td>
</tr>
<tr>
<td>10a. Therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Social Services</td>
<td>177,957</td>
<td>36,481</td>
<td>214,438</td>
<td>214,438</td>
<td>214,438</td>
<td></td>
</tr>
<tr>
<td>15. Other (specify)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. TOTAL Health Care and Programs</td>
<td>4,059,367</td>
<td>127,208</td>
<td>125,561</td>
<td>4,312,136</td>
<td>4,312,136</td>
<td>(19,699)</td>
</tr>
<tr>
<td>C. General Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Administrative</td>
<td>186,864</td>
<td></td>
<td>186,864</td>
<td>186,864</td>
<td>522,016</td>
<td>708,880</td>
</tr>
<tr>
<td>18. Directors Fees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Professional Services</td>
<td>962,569</td>
<td>962,569</td>
<td>962,569</td>
<td>962,569</td>
<td>962,569</td>
<td>(830,211)</td>
</tr>
<tr>
<td>20. Dues, Fees, Subscriptions &amp; Promotions</td>
<td>90,008</td>
<td>90,008</td>
<td>90,008</td>
<td>90,008</td>
<td>90,008</td>
<td>(51,893)</td>
</tr>
<tr>
<td>21. Clerical &amp; General Office Expenses</td>
<td>349,078</td>
<td>86,919</td>
<td>64,959</td>
<td>500,956</td>
<td>500,956</td>
<td>25,767</td>
</tr>
<tr>
<td>23. Inservice Training &amp; Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Other Admin. Staff Transportation</td>
<td>9,091</td>
<td>9,091</td>
<td>9,091</td>
<td>9,091</td>
<td>9,091</td>
<td>11,257</td>
</tr>
<tr>
<td>27. Other (specify)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. TOTAL General Administration</td>
<td>535,942</td>
<td>86,919</td>
<td>2,629,513</td>
<td>3,252,374</td>
<td>3,252,374</td>
<td>(190,181)</td>
</tr>
<tr>
<td>29. TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</td>
<td>5,418,334</td>
<td>717,012</td>
<td>3,304,836</td>
<td>9,440,182</td>
<td>9,440,182</td>
<td>(252,443)</td>
</tr>
</tbody>
</table>

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.
### V. COST CENTER EXPENSES (continued)

<table>
<thead>
<tr>
<th>Capital Expense</th>
<th>Cost Per General Ledger</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage 1</td>
<td>Supplies 2</td>
</tr>
<tr>
<td><strong>D. Ownership</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Depreciation</td>
<td>363,517</td>
<td>363,517</td>
</tr>
<tr>
<td>31 Amortization of Pre-Op. &amp; Org.</td>
<td>167,315</td>
<td>167,315</td>
</tr>
<tr>
<td>32 Interest</td>
<td>935</td>
<td>935</td>
</tr>
<tr>
<td>33 Real Estate Taxes</td>
<td>4,257</td>
<td>4,257</td>
</tr>
<tr>
<td>34 Rent-Facility &amp; Grounds</td>
<td>45,586</td>
<td>935</td>
</tr>
<tr>
<td>35 Rent-Equipment &amp; Vehicles</td>
<td>363,517</td>
<td>363,517</td>
</tr>
<tr>
<td>36 Other (specify):*</td>
<td>524,058</td>
<td>896,493</td>
</tr>
<tr>
<td><strong>TOTAL Ownership</strong></td>
<td>536,024</td>
<td>536,024</td>
</tr>
<tr>
<td><strong>Ancillary Expense</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E. Special Cost Centers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 Medically Necessary Transportation</td>
<td>524,058</td>
<td>896,493</td>
</tr>
<tr>
<td>39 Ancillary Service Centers</td>
<td>116,775</td>
<td>20,163</td>
</tr>
<tr>
<td>40 Barber and Beauty Shops</td>
<td>76,650</td>
<td>76,650</td>
</tr>
<tr>
<td>41 Coffee and Gift Shops</td>
<td>1034,552</td>
<td>1,695,548</td>
</tr>
<tr>
<td>42 Provider Participation Fee</td>
<td>116,775</td>
<td>20,163</td>
</tr>
<tr>
<td>43 Other (specify):*</td>
<td>554,221</td>
<td>1,034,552</td>
</tr>
<tr>
<td><strong>TOTAL Special Cost Centers</strong></td>
<td>116,775</td>
<td>544,221</td>
</tr>
<tr>
<td><strong>GRAND TOTAL COST</strong></td>
<td>536,024</td>
<td>536,024</td>
</tr>
</tbody>
</table>

*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
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.)

<table>
<thead>
<tr>
<th>NON-ALLOWABLE EXPENSES</th>
<th>1 Amount</th>
<th>2 Reference</th>
<th>3 BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Care</td>
<td>$112</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Care for Outpatients</td>
<td>$2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governmental Sponsored Special Programs</td>
<td>$3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Patient Meals</td>
<td>$43,944</td>
<td>02</td>
<td>4</td>
</tr>
<tr>
<td>Telephone, TV &amp; Radio in Resident Rooms</td>
<td>$385</td>
<td>05</td>
<td>5</td>
</tr>
<tr>
<td>Rented Facility Space</td>
<td>$6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of Supplies to Non-Patients</td>
<td>$7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry for Non-Patients</td>
<td>$8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Straighttime Depreciation</td>
<td>$21,306</td>
<td>30</td>
<td>9</td>
</tr>
<tr>
<td>Interest and Other Investment Income</td>
<td>$(5,395)</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>Discounts, Allowances, Rebates &amp; Refunds</td>
<td>$11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Working Officer's or Owner's Salary</td>
<td>$12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales Tax</td>
<td>$2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Care Related Interest</td>
<td>$2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Care Related Owner's Transactions</td>
<td>$15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Expenses (Including Transportation)</td>
<td>$16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Care Related Fees</td>
<td>$17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fines and Penalties</td>
<td>$18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entertainment</td>
<td>$19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions</td>
<td>$20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owner or Key-Man Insurance</td>
<td>$21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Legal Fees &amp; Legal Retainers</td>
<td>$22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malpractice Insurance for Individuals</td>
<td>$23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad Debt</td>
<td>$24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fund Raising, Advertising and Promotional</td>
<td>$(67,051)</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Income Taxes and Illinois Personal</td>
<td>$26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property Replacement Tax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNA Training for Non-Employees</td>
<td>$27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow Page Advertising</td>
<td>$28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other-Attach Schedule</td>
<td>$(245,474)</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>SUBTOTAL (A): (Sum of lines 1-29)</td>
<td>$(340,963)</td>
<td>$30</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Amount Reference</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Paid Workers-Attach Schedule*</td>
<td>$31</td>
<td></td>
</tr>
<tr>
<td>Donated Goods-Attach Schedule*</td>
<td>$32</td>
<td></td>
</tr>
<tr>
<td>Amortization of Organization &amp; Pre-Operating Expense</td>
<td>$33</td>
<td></td>
</tr>
<tr>
<td>Adjustments for Related Organization Costs (Schedule VII)</td>
<td>$34</td>
<td>(19)</td>
</tr>
<tr>
<td>Other-Attach Schedule</td>
<td>$35</td>
<td></td>
</tr>
<tr>
<td>SUBTOTAL (B): (sum of lines 31-35)</td>
<td>$36</td>
<td>(19)</td>
</tr>
<tr>
<td>TOTAL ADJUSTMENTS (A and B)</td>
<td>$37</td>
<td>$(340,982)</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Amount</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td></td>
<td>$39</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td></td>
<td>$41</td>
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<tr>
<td>42</td>
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<td>$42</td>
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<td>43</td>
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<td>$43</td>
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<td>44</td>
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<td>$44</td>
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<td>45</td>
<td></td>
<td>$45</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td></td>
<td>$46</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td></td>
<td>$47</td>
<td></td>
</tr>
</tbody>
</table>

**SEE ACCOUNTANTS' COMPILATION REPORT**
<table>
<thead>
<tr>
<th></th>
<th>NON-ALLOWABLE EXPENSES</th>
<th>Amount</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Finance Charge</td>
<td>$(3,183)</td>
<td>21 1</td>
</tr>
<tr>
<td>2</td>
<td>Sales to Public</td>
<td>$(941)</td>
<td>21 2</td>
</tr>
<tr>
<td>3</td>
<td>Clothing &amp; Personal Supplies</td>
<td>$(6,220)</td>
<td>10 3</td>
</tr>
<tr>
<td>4</td>
<td>Refund on Discounts on Supplies</td>
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<td>Transfer of Fundraising Events</td>
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<td>Non-Care Depreciation</td>
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<td>$(13,817)</td>
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<td>Operating Expenses</td>
<td>PAGES 5 &amp; 5A</td>
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<td>1 Dietary</td>
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<td>2 Food Purchase</td>
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<td>4 Laundry</td>
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<td>5 Heat and Other Utilities</td>
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<td>2,198</td>
<td>(14,202)</td>
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<td>11 Activities</td>
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<td>12 Social Services</td>
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<td>13 CNA Training</td>
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<td>14 Program Transportation</td>
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<td>15 Other (specify):*</td>
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<td>16 TOTAL Health Care and Programs</td>
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<td>C. General Administration</td>
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<td>19 Professional Services</td>
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<td>(181,670)</td>
<td>(145,269)</td>
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<td>140,645</td>
<td>(5,146)</td>
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<td>28 TOTAL General Administration</td>
<td>(72,197)</td>
<td>(98,405)</td>
<td>(12,696)</td>
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<td>(150,326)</td>
<td>(84,193)</td>
<td>(11,041)</td>
</tr>
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<td>Capital Expense</td>
<td>PAGES 5 &amp; 5A</td>
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<tr>
<td><strong>D. Ownership</strong></td>
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<td>32 Interest</td>
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<td>42 Provider Participation Fee</td>
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<td>43 Other (specify):*</td>
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<td>44 TOTAL Special Cost Centers</td>
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<td>(sum of lines 29, 37 &amp; 44)</td>
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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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<th>Name</th>
<th>Ownership %</th>
<th>Name</th>
<th>City</th>
<th>Name</th>
<th>City</th>
<th>Type of Business</th>
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<td>100%</td>
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<td>Rockford, IL</td>
<td>Vesper Mgmt. Corp</td>
<td>Des Plaines, IL</td>
<td>Corporate Office</td>
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</tbody>
</table>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 

[ ] YES  [X] NO

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

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<th>Schedule V</th>
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<th>Amount</th>
<th>Name of Related Organization</th>
<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Difference: Adjustments for Related Organization Costs (7 minus 4)</th>
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* 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. **X** YES  NO  

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

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<th>Line</th>
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<th>Amount</th>
<th>Name of Related Organization</th>
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<th>Operating Cost of Related Organization</th>
<th>Difference: Adjustments for Related Organization Costs (7 minus 4)</th>
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* 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.

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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.

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

SEE ACCOUNTANTS’ COMPILATION REPORT
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.  

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* 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.

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<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Difference: Adjustments for Related Organization Costs (7 minus 4)</th>
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* 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.

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<th>Schedule V Line</th>
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<th>Percent of Ownership</th>
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* 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

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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.  

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* 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.

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</table>

* 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.

<table>
<thead>
<tr>
<th>Schedule V Line</th>
<th>Item</th>
<th>Amount</th>
<th>Name of Related Organization</th>
<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Adjustments for Related Organization Costs (7 minus 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 V</td>
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</table>

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

A. (Continued)  

Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

<table>
<thead>
<tr>
<th>1 OWNERS</th>
<th>2 RELATED NURSING HOMES</th>
<th>3 OTHER RELATED BUSINESS ENTITIES</th>
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<tbody>
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</table>

SEE ACCOUNTANTS' COMPILATION REPORT
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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Function</th>
<th>Ownership Interest</th>
<th>Compensation Received From Other Nursing Homes*</th>
<th>Average Hours Per Work Week Devoted to this Facility and % of Total Work Week</th>
<th>Compensation Included in Costs for this Reporting Period**</th>
<th>Schedule V, Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
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</table>

* 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 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
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.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Schedule V Line Reference</td>
<td>Unit of Allocation</td>
<td>Number of Subunits Being Allocated Among</td>
<td>Total Units</td>
<td>Total Indirect Cost Being Allocated</td>
<td>Amount of Salary Cost Contained in Column 6</td>
<td>Facility Units</td>
<td>Allocation (col.8/col.4)x col.6</td>
</tr>
<tr>
<td>1</td>
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</table>

SEE ACCOUNTANTS' COMPILATION REPORT
## VIII. ALLOCATION OF INDIRECT COSTS

### A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

- **YES** [X]
- **NO**

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

<table>
<thead>
<tr>
<th>Schedule V Unit of Allocation</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Allocation (col.8/col.4)x col.6</th>
</tr>
</thead>
<tbody>
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<td>$3,290,879</td>
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<td>652,990</td>
<td>3,378,086</td>
<td>58,508 2</td>
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<td>3 19 Prof Fees &amp; Contracts</td>
<td>37,701,903 246</td>
<td>150,540</td>
<td>3,378,086</td>
<td>13,488 3</td>
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<td>37,701,903 246</td>
<td>168,123</td>
<td>3,378,086</td>
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<td>3,378,086</td>
<td>2,198 6</td>
</tr>
<tr>
<td>7 6 Building Repairs &amp; Maintenance</td>
<td>37,701,903 246</td>
<td>4,249</td>
<td>3,378,086</td>
<td>218 7</td>
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<td>8 32 Interest</td>
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<td>7,758 8</td>
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<td>9 33 Real Estate Taxes</td>
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**SEE ACCOUNTANTS' COMPILATION REPORT**
### 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.)

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<tr>
<th>Name of Related Organization</th>
<th>Lutheran Social Services of Illinois</th>
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<tr>
<td>Street Address</td>
<td>1001 E. Touhy Avenue, Suite 50</td>
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<tr>
<td>City / State / Zip Code</td>
<td>Des Plaines, Illinois 60018</td>
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<tr>
<td>Phone Number</td>
<td>(847) 635-4600</td>
</tr>
<tr>
<td>Fax Number</td>
<td>(847) 635-6764</td>
</tr>
</tbody>
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#### YES [X] NO [ ]

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

<table>
<thead>
<tr>
<th>Schedule V Line Reference</th>
<th>Item</th>
<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Allocation (col.8/col.4)x col.6</th>
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<td>Salaries &amp; Benefits</td>
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**TOTALS** | $1,996,114 | $1,018,059 | $231,939 | 25 |
### 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.)

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

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<th>Schedule V Line Reference</th>
<th>Item</th>
<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated in Column 6</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Allocation (col.8/col.4) x col.6</th>
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SEE ACCOUNTANTS' COMPILATION REPORT
### 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.)  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
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B. Show the allocation of costs below. If necessary, please attach worksheets.

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<th>Schedule V Line Reference</th>
<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Allocation (col.8/col.4)x col.6</th>
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SEE ACCOUNTANTS' COMPILATION REPORT
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.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Schedule V Line Reference</th>
<th>Unit of Allocation Item</th>
<th>Total Units (i.e., Days, Direct Cost, Square Feet)</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
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SEE ACCOUNTANTS' COMPILATION REPORT
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.

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<td>Number of Subunits Being Allocated Among</td>
<td>Total Indirect Cost Being Allocated</td>
<td>Amount of Salary Cost Contained in Column 6</td>
<td>Facility Units</td>
<td>Allocation (col.8/col.4) x col.6</td>
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SEE ACCOUNTANTS' COMPILATION REPORT
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.)

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<th>Name of Related Organization</th>
<th>Street Address</th>
<th>City / State / Zip Code</th>
<th>Phone Number</th>
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B. Show the allocation of costs below. If necessary, please attach worksheets.

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<th>Schedule V Line Reference</th>
<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Facility Allocation (col.8/col.4)x col.6</th>
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SEE ACCOUNTANTS' COMPILATION REPORT
### 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.

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<th>Facility Units Allocation (col.8/col.4)x col.6</th>
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SEE ACCOUNTANTS’ COMPILATION REPORT
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.)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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B. Show the allocation of costs below. If necessary, please attach worksheets.

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<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
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<td>25 TOTALS</td>
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</tr>
</tbody>
</table>

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.)

<table>
<thead>
<tr>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment Required</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate (4 Digits)</th>
<th>Reporting Period Interest Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
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</table>

A. Directly Facility Related

Long-Term

1. Tax Exempt Bonds X Refinance Bldg. Additions 2/16/06 $3,752,000 $3,300,822 2/16/02 8/0.0523 $167,315 1

2.

3.

4.

5. See Supplemental Schedule 5

Working Capital

6. Allocation LSSI (Schedule VIII) X 13,511 6

7.

8. See Supplemental Schedule 8

9. TOTAL Facility Related $3,752,000 $3,300,822 $180,826 9

B. Non-Facility Related*

10. Interest Income X (5,395) 10

11.

12.

13. See Supplemental Schedule 13

14. TOTAL Non-Facility Related $ $ $ (5,395) 14

15. TOTALS (line 9+line14) $3,752,000 $3,300,822 $175,431 15

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

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

** 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.)

<table>
<thead>
<tr>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment Required</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate (4 Digits)</th>
<th>Reporting Period Interest Expense</th>
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</thead>
<tbody>
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<td>TOTAL Long-Term</td>
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<tr>
<td>Non-Facility Related*</td>
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<td>$</td>
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<td>Non-Facility Related*</td>
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<td>TOTAL Non-Facility Related</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT
<table>
<thead>
<tr>
<th>1.</th>
<th>Real Estate Tax accrual used on 2010 report.</th>
<th>$1</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)</td>
<td>$2</td>
</tr>
<tr>
<td>3.</td>
<td>Under or (over) accrual (line 2 minus line 1).</td>
<td>$3</td>
</tr>
<tr>
<td>4.</td>
<td>Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)</td>
<td>$4</td>
</tr>
<tr>
<td>5.</td>
<td>Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</td>
<td>$5</td>
</tr>
<tr>
<td>6.</td>
<td>Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</td>
<td>$6</td>
</tr>
<tr>
<td>7.</td>
<td>Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.</td>
<td>$7</td>
</tr>
</tbody>
</table>

**Real Estate Tax History:**

<table>
<thead>
<tr>
<th>Real Estate Tax Bill for Calendar Year:</th>
<th>2006</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>2008</td>
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<tr>
<td></td>
<td>2009</td>
<td>11</td>
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<tr>
<td></td>
<td>2010</td>
<td>12</td>
</tr>
</tbody>
</table>

**FOR BHF USE ONLY**

| | FROM R. E. TAX STATEMENT FOR 2010 | $13 |
| | PLUS APPEAL COST FROM LINE 5 | $14 |
| | LESS REFUND FROM LINE 6 | $15 |
| | AMOUNT TO USE FOR RATE CALCULATION | $16 |

**NOTES:**

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

SEE ACCOUNTANTS' COMPILATION REPORT
## 2010 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 2010 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 2010.

<table>
<thead>
<tr>
<th>Tax Index Number</th>
<th>Property Description</th>
<th>Total Tax</th>
<th>Tax Applicable to Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>$</td>
<td>$</td>
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<tr>
<td>3.</td>
<td></td>
<td>$</td>
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<tr>
<td>4.</td>
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<td>5.</td>
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<td>6.</td>
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<td>7.</td>
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<td>8.</td>
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<tr>
<td>9.</td>
<td></td>
<td>$</td>
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<tr>
<td>10.</td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**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 and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

**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.
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.

<table>
<thead>
<tr>
<th>Tax Index Number</th>
<th>Property Description</th>
<th>Total Tax</th>
<th>Tax Applicable to Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2.</td>
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<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3.</td>
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<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4.</td>
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<td>5.</td>
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<tr>
<td>6.</td>
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<td>7.</td>
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<tr>
<td>8.</td>
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<tr>
<td>9.</td>
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<tr>
<td>10.</td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**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.
X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,590

B. General Construction Type:
   - Exterior Masonry
   - Frame Steel Grids

C. Does the Operating Entity?
   - (a) Own the Facility  X
   - (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  X
   - (b) Rent equipment from a Related Organization.  X
   - (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

   List entity name, type of business, square footage, and number of beds/units available (where applicable).

   None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  
   - YES  X  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:

<table>
<thead>
<tr>
<th>A. Land.</th>
<th>1</th>
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<th>3</th>
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</thead>
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<td></td>
<td>1</td>
<td>Use</td>
<td>Square Feet</td>
<td>Year Acquired</td>
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<td>TOTALS</td>
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<td></td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' COMPILATION REPORT
### B. Building and Improvement Costs-Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

<table>
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<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td></td>
<td>Beds*</td>
<td>FOR BHF USE ONLY</td>
<td>Year Acquired</td>
<td>Year Constructed</td>
<td>Cost</td>
<td>Current Book Depreciation</td>
<td>Life in Years</td>
<td>Straight Line Depreciation</td>
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#### Improvement Type**

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*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' COMPILED REPORT

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

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<tr>
<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>4 Cost</th>
<th>5 Current Book Depreciation</th>
<th>6 Life in Years</th>
<th>7 Straight Line Depreciation</th>
<th>8 Adjustments</th>
<th>9 Accumulated Depreciation</th>
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<td>$(190,998)</td>
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SEE ACCOUNTANTS’ COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.
### XL. OWNERSHIP COSTS (continued)

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

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<th>Straight Line Depreciation</th>
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**Improvement type must be detailed in order for the cost report to be considered complete.**
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<th>Current Book Depreciation</th>
<th>Life in Years</th>
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<td>34 TOTAL (lines 1 thru 33)</td>
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<td>$396,882</td>
<td>$260,492</td>
<td>(136,390)</td>
<td>$6,080,926</td>
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SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.
## B. Building and Improvement Costs—Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

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**Improvement type must be detailed in order for the cost report to be considered complete.**
**XL. OWNERSHIP COSTS (continued)**

B. Building and Improvement Costs–Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

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<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
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*SEE ACCOUNTANTS’ COMPILATION REPORT*
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

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<th>Life in Years</th>
<th>Straight Line Depreciation</th>
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SEE ACCOUNTANTS' COMPILATION REPORT

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

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<th>6 Life in Years</th>
<th>7 Straight Line Depreciation</th>
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</table>

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

SEE ACCOUNTANTS' COMPILATION REPORT
### B. Building and Improvement Costs-Including Fixed Equipment

Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Constructed</th>
<th>Cost</th>
<th>Current Book Depreciation</th>
<th>Life in Years</th>
<th>Straight Line Depreciation</th>
<th>Adjustments</th>
<th>Accumulated Depreciation</th>
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<td>7 Leasehold Improvements:</td>
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SEE ACCOUNTANTS’ COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.
### B. Building and Improvement Costs-Including Fixed Equipment

(See instructions.) Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>1</th>
<th>2</th>
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<tr>
<td>Related Party Information Continued</td>
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</table>
XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

<table>
<thead>
<tr>
<th>Category of Equipment</th>
<th>1 Cost</th>
<th>Current Book Depreciation</th>
<th>Straight Line Depreciation</th>
<th>4 Adjustments</th>
<th>Component Life</th>
<th>5 Accumulated Depreciation</th>
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<tbody>
<tr>
<td>71 Bought in Prior Years</td>
<td>$1,865,545</td>
<td>$153,668</td>
<td>$153,668</td>
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<td>$1,487,644</td>
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<tr>
<td>72 Current Year Purchases</td>
<td>40,281</td>
<td>4,028</td>
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<td>4,028</td>
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<tr>
<td>73 Fully Depreciated Assets</td>
<td>387,278</td>
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<td>75 TOTALS</td>
<td>$2,293,104</td>
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<td>$1,878,951</td>
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</table>

D. Vehicle Costs. (See instructions.)*

<table>
<thead>
<tr>
<th>1 Use</th>
<th>2 Model, Make and Year</th>
<th>3 Year Acquired</th>
<th>4 Cost</th>
<th>5 Current Book Depreciation</th>
<th>6 Straight Line Depreciation</th>
<th>7 Adjustments</th>
<th>8 Life in Years</th>
<th>9 Accumulated Depreciation</th>
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<td>76</td>
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<td>80 TOTALS</td>
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E. Summary of Care-Related Assets

<table>
<thead>
<tr>
<th>1 Reference</th>
<th>2 Amount</th>
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<tbody>
<tr>
<td>81 Total Historical Cost</td>
<td>$11,676,071</td>
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<tr>
<td>82 Current Book Depreciation</td>
<td>$396,882</td>
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<tr>
<td>83 Straight Line Depreciation</td>
<td>$418,189 **</td>
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<tr>
<td>84 Adjustments</td>
<td>$21,306</td>
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<tr>
<td>85 Accumulated Depreciation</td>
<td>$7,959,877</td>
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</table>

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

<table>
<thead>
<tr>
<th>1 Description &amp; Year Acquired</th>
<th>2 Cost</th>
<th>3 Current Book Depreciation</th>
<th>4 Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>86 Pickup Truck - 1900</td>
<td>$25,994</td>
<td>$1,415</td>
<td>$25,994</td>
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<td>87 Bus - 1900</td>
<td>46,956</td>
<td>6,654</td>
<td>44,678</td>
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<td>88 Countertops for Rainbow Hospice - 2011</td>
<td>2,648</td>
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<td>89</td>
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<tr>
<td>91 TOTALS</td>
<td>$75,240</td>
<td>$8,201</td>
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</table>

SEE ACCOUNTANTS' COMPILATION REPORT

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

** This must agree with Schedule V line 30, column 8.
### XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>3</td>
<td>Original Building:</td>
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<td>Additions</td>
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</table>

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: 2012 $ 12
   - Fiscal Year Ending: 2013 $ 13
   - Fiscal Year Ending: 2014 $ 14

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

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

16. Rental Amount for movable equipment: $ 1,924 Description: See Attached Schedule

C. Vehicle Rental (See instructions.)

17. Allocation LSSI (Schedule VIII) $ 447

18

19

20

21

TOTAL $ 447

SEE ACCOUNTANTS' COMPILATION REPORT
A. TYPE OF TRAINING PROGRAM

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? YES NO

2. CLASSROOM PORTION:

3. CLINICAL PORTION:

B. EXPENSES

ALLOCATION OF COSTS (d)

<table>
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<tr>
<th>Facility</th>
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<tr>
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<td>Drop-outs</td>
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<td>Community College Tuition</td>
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<td>Clinical Wages (b)</td>
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<td>In-House Trainer Wages (c)</td>
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<td>CNA Competency Tests</td>
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<tr>
<td>9</td>
<td>TOTALS</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10</td>
<td>SUM OF line 9, col. 1 and 2 (e)</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>COMPLETED</th>
<th>DROP-OUTS</th>
<th>TOTAL TRAINED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From this facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. From this facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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

(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.

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

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Line &amp; Column Reference</th>
<th>Units of Service</th>
<th>Cost (Actual or Allocated)</th>
<th>Total Units (Column 2 + 4)</th>
<th>Total Cost (Col. 3 + 5 + 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Licensed Occupational Therapist</td>
<td>39 - 03 hrs</td>
<td>$317,600</td>
<td>$317,600</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>2 Licensed Speech and Language Development Therapist</td>
<td>39 - 03 hrs</td>
<td>$176,794</td>
<td>$176,794</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>3 Licensed Recreational Therapist</td>
<td>hrs</td>
<td>$362,048</td>
<td>$362,048</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>4 Licensed Physical Therapist</td>
<td>39 - 03 hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Physician Care</td>
<td>visits</td>
<td>$9,041</td>
<td>$9,041</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>6 Dental Care</td>
<td>39 - 03 visits</td>
<td>$9,041</td>
<td>$9,041</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>7 Work Related Program</td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>8 Habilitation</td>
<td>hrs</td>
<td>$300,856</td>
<td>$300,856</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>9 Pharmacy</td>
<td>39 - 02 # of prescrpts</td>
<td>$310,10</td>
<td>$223,202</td>
<td>$524,058</td>
<td>$1,420,551</td>
</tr>
<tr>
<td>10 Psychological Services (Evaluation and Diagnosis/ Behavior Modification)</td>
<td>hrs</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Academic Education</td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>12 Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>13 Other (specify): See Supplemental</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>14 TOTAL</td>
<td></td>
<td>$896,493</td>
<td>$524,058</td>
<td>$1,420,551</td>
<td></td>
</tr>
</tbody>
</table>

**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
### XV. BALANCE SHEET - Unrestricted Operating Fund

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

<table>
<thead>
<tr>
<th>A. Current Assets</th>
<th>Operating</th>
<th>After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Cash on Hand and in Banks</td>
<td>$126</td>
<td>$1</td>
</tr>
<tr>
<td>2 Cash-Patient Deposits</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Accounts &amp; Short-Term Notes Receivable-Patients (less allowance)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 Supply Inventory (priced at )</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5 Short-Term Investments</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6 Prepaid Insurance</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7 Other Prepaid Expenses</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8 Accounts Receivable (owners or related parties)</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9 Other(specify): See Attached Schedule</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Current Assets</strong></td>
<td><strong>$10</strong></td>
<td><strong>$10</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Long-Term Assets</th>
<th>Operating</th>
<th>After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Long-Term Notes Receivable</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12 Long-Term Investments</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>13 Land</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14 Buildings, at Historical Cost</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>15 Leasehold Improvements, at Historical Cost</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>16 Equipment, at Historical Cost</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>17 Accumulated Depreciation (book methods)</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>18 Deferred Charges</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>19 Organization &amp; Pre-Operating Costs</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>20 Accumulated Amortization - Organization &amp; Pre-Operating Costs</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>21 Restricted Funds</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>22 Other Long-Term Assets (specify):</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>23 Other(specify): See Attached Schedule</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Long-Term Assets</strong></td>
<td><strong>$24</strong></td>
<td><strong>$24</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Current Liabilities</th>
<th>Operating</th>
<th>After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 Accounts Payable</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>27 Officer's Accounts Payable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Accounts Payable-Patient Deposits</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>29 Short-Term Notes Payable</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>30 Accrued Salaries Payable</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>31 Accrued Taxes Payable (excluding real estate taxes)</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>32 Accrued Real Estate Taxes(Sch.IX-B)</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>33 Accrued Interest Payable</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>34 Deferred Compensation</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>35 Federal and State Income Taxes</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Current Liabilities</strong></td>
<td><strong>$38</strong></td>
<td><strong>$38</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Long-Term Liabilities</th>
<th>Operating</th>
<th>After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>39 Long-Term Notes Payable</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>40 Mortgage Payable</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>41 Bonds Payable</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>42 Deferred Compensation</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Long-Term Liabilities</strong></td>
<td><strong>$45</strong></td>
<td><strong>$45</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTAL ASSETS</th>
<th>Operating</th>
<th>After Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td><strong>$25</strong></td>
<td><strong>$25</strong></td>
</tr>
</tbody>
</table>

SEE ACCOUNTANTS' COMPILATION REPORT *(See instructions.)*
### XVI. STATEMENT OF CHANGES IN EQUITY

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>1 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Balance at Beginning of Year, as Previously Reported $</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Restatements (describe):</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Balance at Beginning of Year, as Restated (sum of lines 1-5) $</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>A. Additions (deductions):</strong></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>NET Income (Loss) (from page 19, line 43)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Acquisitions of Pooled Companies</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Proceeds from Sale of Stock</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Stock Options Exercised</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Contributions and Grants</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Expenditures for Specific Purposes</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Dividends Paid or Other Distributions to Owners ( )</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>Donated Property, Plant, and Equipment</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td><strong>TOTAL Additions (deductions) (sum of lines 7-16)</strong> $</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td><strong>B. Transfers (Itemize):</strong></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td><strong>TOTAL Transfers (sum of lines 18-22)</strong> $</td>
<td>23</td>
</tr>
<tr>
<td>24</td>
<td><strong>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</strong> $</td>
<td>24 *</td>
</tr>
</tbody>
</table>

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT
**STATE OF ILLINOIS**

Facility Name & ID Number: St. Matthew Center For Health

# 0013896

Report Period Beginning: 07/01/10

Ending: 06/30/11

---

**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.

---

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Inpatient Care</td>
<td></td>
</tr>
<tr>
<td>1 Gross Revenue -- All Levels of Care $11,452,224</td>
<td></td>
</tr>
<tr>
<td>2 Discounts and Allowances for all Levels $(347,700)</td>
<td></td>
</tr>
<tr>
<td>3 SUBTOTAL Inpatient Care (line 1 minus line 2) $11,104,524</td>
<td></td>
</tr>
<tr>
<td>B. Ancillary Revenue</td>
<td></td>
</tr>
<tr>
<td>4 Day Care $43,923</td>
<td></td>
</tr>
<tr>
<td>5 Other Care for Outpatients $35,923</td>
<td></td>
</tr>
<tr>
<td>6 Oxygen $8,231</td>
<td></td>
</tr>
<tr>
<td>7 SUBTOTAL Ancillary Revenue (lines 4 thru 7) $362,154</td>
<td></td>
</tr>
<tr>
<td>C. Other Operating Revenue</td>
<td></td>
</tr>
<tr>
<td>8 Payments for Education $9</td>
<td></td>
</tr>
<tr>
<td>9 Other Government Grants $10</td>
<td></td>
</tr>
<tr>
<td>10 CNA Training Reimbursements</td>
<td>$11</td>
</tr>
<tr>
<td>11 Gift and Coffee Shop $12</td>
<td></td>
</tr>
<tr>
<td>12 Barber and Beauty Care $2,100</td>
<td></td>
</tr>
<tr>
<td>13 Non-Patient Meals $43,344</td>
<td></td>
</tr>
<tr>
<td>14 Telephone, Television and Radio $385</td>
<td></td>
</tr>
<tr>
<td>15 Rental of Facility Space $16</td>
<td></td>
</tr>
<tr>
<td>16 Sale of Drugs $17</td>
<td></td>
</tr>
<tr>
<td>17 Sale of Supplies to Non-Patients</td>
<td></td>
</tr>
<tr>
<td>18 Laboratory $19</td>
<td></td>
</tr>
<tr>
<td>19 Radiology and X-Ray $158</td>
<td></td>
</tr>
<tr>
<td>20 Other Medical Services $(242)</td>
<td></td>
</tr>
<tr>
<td>21 Laundry $22</td>
<td></td>
</tr>
<tr>
<td>22 SUBTOTAL Other Operating Revenue (lines 9 thru 22) $46,345</td>
<td></td>
</tr>
<tr>
<td>D. Non-Operating Revenue</td>
<td></td>
</tr>
<tr>
<td>23 Contributions $138,023</td>
<td></td>
</tr>
<tr>
<td>24 Interest and Other Investment Income $5,395</td>
<td></td>
</tr>
<tr>
<td>25 SUBTOTAL Non-Operating Revenue (lines 23 and 24) $143,418</td>
<td></td>
</tr>
<tr>
<td>26 Other Revenue (specify) $550,159</td>
<td></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Operating Expenses</td>
<td></td>
</tr>
<tr>
<td>31 General Services $1,875,672</td>
<td></td>
</tr>
<tr>
<td>32 Health Care $4,312,136</td>
<td></td>
</tr>
<tr>
<td>33 General Administration $3,252,374</td>
<td></td>
</tr>
<tr>
<td>B. Capital Expense</td>
<td></td>
</tr>
<tr>
<td>34 Ownership $536,024</td>
<td></td>
</tr>
<tr>
<td>C. Ancillary Expense</td>
<td></td>
</tr>
<tr>
<td>35 Special Cost Centers $1,618,898</td>
<td></td>
</tr>
<tr>
<td>36 Provider Participation Fee $76,650</td>
<td></td>
</tr>
<tr>
<td>D. Other Expenses (specify)</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td></td>
</tr>
<tr>
<td>40 TOTAL EXPENSES (sum of lines 31 thru 39)* $1,167,754</td>
<td></td>
</tr>
<tr>
<td>41 Income before Income Taxes (line 30 minus line 40)** $534,846</td>
<td></td>
</tr>
<tr>
<td>42 Income Taxes</td>
<td>$42</td>
</tr>
<tr>
<td>43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) $534,846</td>
<td></td>
</tr>
</tbody>
</table>

---

* 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.
### B. CONSULTANT SERVICES

<table>
<thead>
<tr>
<th>Line</th>
<th>Number of Hrs. Paid &amp; Accrued</th>
<th>Total Consultant Cost for Reporting Period</th>
<th>Schedule V Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>As Needed</td>
<td>$149,068</td>
<td>01-03</td>
</tr>
<tr>
<td>36</td>
<td>As Needed</td>
<td>$70,400</td>
<td>09-03</td>
</tr>
<tr>
<td>37</td>
<td>As Needed</td>
<td>$2,920</td>
<td>10-03</td>
</tr>
<tr>
<td>38</td>
<td>As Needed</td>
<td>$7,195</td>
<td>10-03</td>
</tr>
<tr>
<td>39</td>
<td>As Needed</td>
<td>$8,301</td>
<td>10-03</td>
</tr>
<tr>
<td>40</td>
<td>Physical Therapy Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Occupational Therapy Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Respiratory Therapy Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Speech Therapy Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>As Needed</td>
<td>$264</td>
<td>11-03</td>
</tr>
<tr>
<td>45</td>
<td>Social Service Consultant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Other(specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>As Needed</td>
<td>$36,481</td>
<td>12-03</td>
</tr>
<tr>
<td>48</td>
<td>Other(specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>TOTAL (lines 35 - 48)</td>
<td>$274,629</td>
<td>49</td>
</tr>
</tbody>
</table>

### C. CONTRACT NURSES

<table>
<thead>
<tr>
<th>Line</th>
<th>Number of Hrs. Paid &amp; Accrued</th>
<th>Total Contract Wages</th>
<th>Schedule V Line &amp; Column Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Registered Nurses</td>
<td>$18,962</td>
<td>01-03</td>
</tr>
<tr>
<td>51</td>
<td>Licensed Practical Nurses</td>
<td>$24,600</td>
<td>02-03</td>
</tr>
<tr>
<td>52</td>
<td>Certified Nurse Assistants/Aides</td>
<td>$27,300</td>
<td>03-03</td>
</tr>
<tr>
<td>53</td>
<td>TOTAL (lines 50 - 52)</td>
<td>$70,800</td>
<td>04-03</td>
</tr>
<tr>
<td>Name</td>
<td>Function</td>
<td>%</td>
<td>Amount</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------</td>
<td>------</td>
<td>---------</td>
</tr>
<tr>
<td>Steven St. Louis</td>
<td>Administrator</td>
<td>52%</td>
<td>$83,947</td>
</tr>
<tr>
<td>Jonathan Moy</td>
<td>Assist. Administrator</td>
<td>50%</td>
<td>$52,780</td>
</tr>
<tr>
<td>Kelly Fitzgerald</td>
<td>Assist. Administrator</td>
<td>48%</td>
<td>$50,137</td>
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</tbody>
</table>

**Administrative Salaries**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers' Compensation Insurance</td>
<td>$130,722</td>
</tr>
<tr>
<td>Unemployment Compensation Insurance</td>
<td>$26,640</td>
</tr>
<tr>
<td>FICA Taxes</td>
<td>$403,523</td>
</tr>
<tr>
<td>Employee Health Insurance</td>
<td>$537,657</td>
</tr>
<tr>
<td>Employee Meals</td>
<td>$186,864</td>
</tr>
<tr>
<td>Illinois Municipal Retirement Fund (IMRF)*</td>
<td>$12,752</td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>$11,831</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>$7,499</td>
</tr>
<tr>
<td>Pension</td>
<td>$198,474</td>
</tr>
<tr>
<td>Other Benefits</td>
<td>$910</td>
</tr>
<tr>
<td>LSSI Allocation (Schedule VIII)</td>
<td>$107,900</td>
</tr>
<tr>
<td>Illinois Municipal Retirement Fund (IMRF)*</td>
<td>$12,752</td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>$11,831</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>$7,499</td>
</tr>
<tr>
<td>Pension</td>
<td>$198,474</td>
</tr>
<tr>
<td>Other Benefits</td>
<td>$910</td>
</tr>
<tr>
<td>LSSI Allocation (Schedule VIII)</td>
<td>$107,900</td>
</tr>
</tbody>
</table>

**TOTAL (agree to Schedule V, line 17, col.1)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$1,425,247</td>
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</tbody>
</table>

**B. Administrative - Other**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois Municipal Retirement Fund (IMRF)*</td>
<td>$12,752</td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>$11,831</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>$7,499</td>
</tr>
<tr>
<td>Pension</td>
<td>$198,474</td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>$11,831</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>$7,499</td>
</tr>
<tr>
<td>Pension</td>
<td>$198,474</td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>$11,831</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>$7,499</td>
</tr>
<tr>
<td>Pension</td>
<td>$198,474</td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>$11,831</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>$7,499</td>
</tr>
<tr>
<td>Pension</td>
<td>$198,474</td>
</tr>
</tbody>
</table>

**TOTAL (agree to Schedule V, line 22, col. 8)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$38,114</td>
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</tbody>
</table>

**TOTAL (agree to Schedule V, line 17, col.3)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$962,568</td>
</tr>
</tbody>
</table>

**C. Professional Services**

<table>
<thead>
<tr>
<th>Vendor/Payee</th>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baker Tilly Virchow Krause, LLP</td>
<td>Accounting</td>
<td>$50,993</td>
</tr>
<tr>
<td>Debra Evertsen</td>
<td>Accounting</td>
<td>$2,063</td>
</tr>
<tr>
<td>FR&amp;R</td>
<td>Accounting</td>
<td>$1,400</td>
</tr>
<tr>
<td>Qnust Software Systems</td>
<td>Computer Software</td>
<td>$854</td>
</tr>
<tr>
<td>SWC Technology Partners, Inc.</td>
<td>Info System Consultant</td>
<td>$3,970</td>
</tr>
<tr>
<td>LSSI</td>
<td>Management Services</td>
<td>$903,288</td>
</tr>
</tbody>
</table>

**TOTAL (agree to Schedule V, line 19, column 3)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Line #</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$962,568</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL (agree to Sch. V, line 24, col. 8)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$50,286</td>
</tr>
</tbody>
</table>

**D. Employee Benefits and Payroll Taxes**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>IDPH License Fee</td>
<td>$</td>
</tr>
<tr>
<td>Advertisement; Employee Recruitment</td>
<td>$</td>
</tr>
<tr>
<td>Health Care Worker Background Check</td>
<td>$7,936</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$</td>
</tr>
</tbody>
</table>

**G. Schedule of Travel and Seminar**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-State Travel</td>
<td>$</td>
</tr>
</tbody>
</table>

**Attach copy of IMRF notifications**

SEE ACCOUNTANTS' COMPILATION REPORT
### XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

<table>
<thead>
<tr>
<th>Improvement Type</th>
<th>Month &amp; Year Improvement Was Made</th>
<th>Total Cost</th>
<th>Useful Life</th>
<th>Amount of Expense Amortized Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>N/A</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
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<tr>
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<tr>
<td>5</td>
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<td>6</td>
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<td>7</td>
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<td>8</td>
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<td>10</td>
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<td>15</td>
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<td>17</td>
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<tr>
<td>18</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>TOTALS</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

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

(3) Did the nursing home make political contributions or payments to a political action organization? No

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No

(5) Have you properly capitalized all major repairs and equipment purchases? Yes

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $39,166 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes

(8) Are you presently operating under a sale and leaseback arrangement? No

(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 X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $76,650

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No

(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. $43,944

(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. $0

   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. $0

(17) Has an audit been performed by an independent certified public accounting firm? Yes

   Firm Name: Baker Tilly Virchow Krause, LLP

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

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

Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT