FOR BHF USE

LL1

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

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0013896

Facility Name: St. Matthew Center For Health

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 00/00/59

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/10 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)
(Date)
(Type or Print Name)
(Title)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

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

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.91%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 51 and days of care provided 8,170

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/11 Fiscal Year: 6/30/11

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	437,856	38,046	149,068	624,970		624,970		624,970			1
2	Food Purchase		389,136		389,136		389,136	(43,944)	345,192			2
3	Housekeeping	171,798	36,277		208,075		208,075		208,075			3
4	Laundry	72,437	17,359	13,063	102,859		102,859		102,859			4
5	Heat and Other Utilities			217,174	217,174		217,174	(12,004)	205,170			5
6	Maintenance	140,934	22,067	170,457	333,458		333,458	11,380	344,838			6
7	Other (specify):*							2,005	2,005			7
8	**TOTAL General Services**	823,025	502,885	549,762	1,875,672		1,875,672	(42,563)	1,833,109			8
	B. Health Care and Programs											
9	Medical Director			70,400	70,400		70,400		70,400			9
10	Nursing and Medical Records	3,646,696	103,684	18,416	3,768,796		3,768,796	(19,699)	3,749,097			10
10a	Therapy											10a
11	Activities	234,714	23,524	264	258,502		258,502		258,502			11
12	Social Services	177,957		36,481	214,438		214,438		214,438			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,059,367	127,208	125,561	4,312,136		4,312,136	(19,699)	4,292,437			16
	C. General Administration											
17	Administrative	186,864			186,864		186,864	522,016	708,880			17
18	Directors Fees											18
19	Professional Services			962,569	962,569		962,569	(830,211)	132,358			19
20	Dues, Fees, Subscriptions & Promotions			90,008	90,008		90,008	(51,893)	38,115			20
21	Clerical & General Office Expenses	349,078	86,919	64,959	500,956		500,956	25,767	526,723			21
22	Employee Benefits & Payroll Taxes			1,317,257	1,317,257		1,317,257	107,990	1,425,247			22
23	Inservice Training & Education											23
24	Travel and Seminar			40,178	40,178		40,178	10,108	50,286			24
25	Other Admin. Staff Transportation			9,091	9,091		9,091	11,257	20,348			25
26	Insurance-Prop.Liab.Malpractice			145,451	145,451		145,451	14,785	160,236			26
27	Other (specify):*											27
28	**TOTAL General Administration**	535,942	86,919	2,629,513	3,252,374		3,252,374	(190,181)	3,062,193			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,418,334	717,012	3,304,836	9,440,182		9,440,182	(252,443)	9,187,739			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: 07/01/10 Ending: 06/30/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			363,517	363,517		363,517	54,671	418,188			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			167,315	167,315		167,315	8,116	175,431			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							45,586	45,586			34
35	Rent-Equipment & Vehicles			935	935		935	1,436	2,371			35
36	Other (specify):*			4,257	4,257		4,257		4,257			36
37	**TOTAL Ownership**			536,024	536,024		536,024	109,809	645,833			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		524,058	896,493	1,420,551		1,420,551		1,420,551			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,650	76,650		76,650		76,650			42
43	Other (specify):*	116,775	20,163	61,409	198,347		198,347	(198,347)				43
44	**TOTAL Special Cost Centers**	116,775	544,221	1,034,552	1,695,548		1,695,548	(198,347)	1,497,201			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,535,109	1,261,233	4,875,412	11,671,754		11,671,754	(340,982)	11,330,772			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: 07/01/10 Ending: 06/30/11

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(43,944)	02		4
5	Telephone, TV & Radio in Resident Rooms	(385)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,306	30		9
10	Interest and Other Investment Income	(5,395)	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	(67,051)	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	(245,494)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (340,963)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

St. Matthew Center For Health

ID# 0013896

Report Period Beginning: 07/01/10

Ending: 06/30/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Finance Charge	$ (3,183)	21	1
2	Sales to Public	(941)	21	2
3	Clothing & Personal Supplies	(6,220)	10	3
4	Refund on Discounts on Supplies	(13,479)	10	4
5	Marketing Salary	(53,649)	43	5
6	Additional R&M	9,570	6	6
7	Capitalized R&M	(9,854)	6	7
8	Transfer of Fundrising Events	(1,022)	21	8
9	Non-Care Depreciation	(8,201)	30	9
10	Expenses related to unrelated Hospice Co.	(144,698)	43	10
11	ComEd Incentive	(13,817)	05	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**	(245,494)		49

St. Matthew Center For Health

ID# 0013896

Report Period Beginning: 07/01/10

Ending: 06/30/11

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Matthew Center For Health # 0013896 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(43,944)											(43,944)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(14,202)		2,198									(12,004)	5
6	Maintenance	(284)		10,014	1,650								11,380	6
7	Other (specify):*			2,000	5								2,005	7
8	**TOTAL General Services**	(58,430)		14,212	1,655								(42,563)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(19,699)											(19,699)	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**	(19,699)											(19,699)	16
	C. General Administration													
17	Administrative			294,862	118,293	108,860							522,016	17
18	Directors Fees													18
19	Professional Services			(503,272)	(181,670)	(145,269)							(830,211)	19
20	Fees, Subscriptions & Promotions	(67,051)		2,243	12,363	552							(51,893)	20
21	Clerical & General Office Expenses	(5,146)		25,695	3,666	1,552							25,767	21
22	Employee Benefits & Payroll Taxes			58,508	28,556	20,926							107,990	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,902	4,660	1,546							10,108	24
25	Other Admin. Staff Transportation			5,484	1,054	4,719							11,257	25
26	Insurance-Prop.Liab.Malpractice			14,173	382	230							14,785	26
27	Other (specify):*													27
28	**TOTAL General Administration**	(72,197)		(98,405)	(12,696)	(6,884)							(190,181)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(150,326)		(84,193)	(11,041)	(6,884)							(252,443)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Matthew Center For Health # 0013896 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

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

	Capital Expense D. Ownership	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)	
30	Depreciation	13,105		32,717	7,082	1,767							54,671	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(5,395)		7,758	1,023	4,730							8,116	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			42,832	2,754								45,586	34
35	Rent-Equipment & Vehicles			874	182	380							1,436	35
36	Other (specify):*													36
37	**TOTAL Ownership**	7,710		84,181	11,041	6,876							109,809	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													42
43	Other (specify):*	(198,347)											(198,347)	43
44	**TOTAL Special Cost Centers**	(198,347)											(198,347)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(340,963)		(12)	0	(7)							(340,982)	45

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

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.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LSSI	100%	P.A Peterson	Rockford, IL	Vesper Mgmt. Corp	Des Plaines, IL	Management Co.
				LSSI	Des Plaines, IL	Corporate Office

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages	$	Lutheran Social Services of Illinois - Management Allocation	100.00%	$ 294,862	$ 294,862	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	58,508	58,508	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	13,488	13,488	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Management Allocation	100.00%	15,064	15,064	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	42,832	42,832	19
20	V	5	Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,198	2,198	20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	218	218	21
22	V	32	Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	7,758	7,758	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%	14,173	14,173	24
25	V	20	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%	5,484	5,484	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	265	265	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	3,902	3,902	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	2,243	2,243	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%	609	609	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	9,795	9,795	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%	2,000	2,000	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	10,631	10,631	36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	32,717	32,717	37
38	V	19	Management Allocation	516,760	Lutheran Social Services of Illinois - Management Allocation	100.00%		(516,760)	38
39	Total			$ 516,760			$ 516,748	$ * (12)	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: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages	$	Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	$ 118,293	$ 118,293	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	28,556	28,556	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	50,269	50,269	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	3,579	3,579	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	2,754	2,754	19
20	V	5	Utilities		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%			20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%			21
22	V	32	Interest		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	1,023	1,023	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%			23
24	V	26	Insurance		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	382	382	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%			25
26	V	25	Transportation		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	1,054	1,054	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	182	182	27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	4,660	4,660	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	826	826	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%			30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%			32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	1,650	1,650	33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	11,537	11,537	34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	5	5	35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	87	87	36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Human Resources Allocation	100.00%	7,082	7,082	37
38	V	19	Human Resource Allocation	231,939	Lutheran Social Services of Illinois - Human Resources Allocation	100.00%		(231,939)	38
39	Total			$ 231,939			$ 231,939	$ * 0	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: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Salaries & Wages	$	Lutheran Social Services of Illinois - Service Network Allocation	100.00%	$ 108,860	$ 108,860	15
16	V	22	Empl Benefits & Taxes		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	20,926	20,926	16
17	V	19	Prof Fees & Contracts		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	9,320	9,320	17
18	V	21	Supplies, Telephone,		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	1,552	1,552	18
19	V	34	Rental of Space		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			19
20	V	5	Utilities		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			20
21	V	6	Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			21
22	V	32	Interest		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	4,730	4,730	22
23	V	33	Real Estate Taxes		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			23
24	V	26	Insurance		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	230	230	24
25	V	20	Advertising & Promotions		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	409	409	25
26	V	25	Transportation		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	4,719	4,719	26
27	V	35	Car Rental		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			27
28	V	24	Conferences & Conventions		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	1,546	1,546	28
29	V	20	Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	107	107	29
30	V	6	Furniture & Fixtures		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			30
31	V	6	Machinery & Equipment		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			31
32	V	35	Equipment Rental		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	380	380	32
33	V	6	Equipment Repair & Maint.		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			33
34	V	20	Employee Recruitment		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	35	35	34
35	V	7	Security & Waste Removal		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			35
36	V	21	All Other Miscellaneous		Lutheran Social Services of Illinois - Service Network Allocation	100.00%			36
37	V	30	Depreciation		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	1,767	1,767	37
38	V	19	Service Network Allocation	154,589	Lutheran Social Services of Illinois - Service Network Allocation	100.00%		(154,589)	38
39	Total			$ 154,589			$ 154,582	$ * (7)	39

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

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	37,701,903	246	$ 3,290,879	$ 3,290,879	3,378,086	$ 294,862	1
2	22	Empl Benefits & Taxes		37,701,903	246	652,990		3,378,086	58,508	2
3	19	Prof Fees & Contracts		37,701,903	246	150,540		3,378,086	13,488	3
4	21	Supplies, Telephone,		37,701,903	246	168,123		3,378,086	15,064	4
5		Postage, Out. Printing		37,701,903	246			3,378,086		5
6	34	Rental of Space		37,701,903	246	478,040		3,378,086	42,832	6
7	5	Utilities		37,701,903	246	24,532		3,378,086	2,198	7
8	6	Bldg Repairs & Maintenance		37,701,903	246	2,429		3,378,086	218	8
9	32	Interest		37,701,903	246	86,587		3,378,086	7,758	9
10	33	Real Estate Taxes		37,701,903	246			3,378,086		10
11	26	Insurance		37,701,903	246	158,177		3,378,086	14,173	11
12	20	Advertising & Promotions		37,701,903	246			3,378,086		12
13	25	Transportation		37,701,903	246	61,200		3,378,086	5,484	13
14	35	Car Rental		37,701,903	246	2,962		3,378,086	265	14
15	24	Conferences & Conventions		37,701,903	246	43,548		3,378,086	3,902	15
16	20	Subscriptions, Dues, Awards		37,701,903	246	25,037		3,378,086	2,243	16
17	6	Furniture & Fixtures		37,701,903	246	7		3,378,086	1	17
18	6	Machinery & Equipment		37,701,903	246			3,378,086		18
19	35	Equipment Rental		37,701,903	246	6,796		3,378,086	609	19
20	6	Equipment Repair & Maint.		37,701,903	246	109,316		3,378,086	9,795	20
21	20	Employee Recruitment		37,701,903	246			3,378,086		21
22	7	Security & Waste Removal		37,701,903	246	22,318		3,378,086	2,000	22
23	21	All Other Miscellaneous		37,701,903	246	118,647		3,378,086	10,631	23
24	30	Depreciation		37,701,903	246	365,146		3,378,086	32,717	24
25	TOTALS					$ 5,767,274	$ 3,290,879		$ 516,748	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	58,973,306	231	$ 1,018,059	$ 1,018,059	6,852,411	$ 118,293	1
2	22	Empl Benefits & Taxes		58,973,306	231	245,761		6,852,411	28,556	2
3	19	Prof Fees & Contracts		58,973,306	231	432,623		6,852,411	50,269	3
4	21	Supplies, Telephone,		58,973,306	231			6,852,411		4
5		Postage, Out. Printing		58,973,306	231	30,798		6,852,411	3,579	5
6	34	Rental of Space		58,973,306	231	23,698		6,852,411	2,754	6
7	5	Utilities		58,973,306	231			6,852,411		7
8	6	Bldg Repairs & Maintenance		58,973,306	231			6,852,411		8
9	32	Interest		58,973,306	231	8,800		6,852,411	1,023	9
10	33	Real Estate Taxes		58,973,306	231			6,852,411		10
11	26	Insurance		58,973,306	231	3,291		6,852,411	382	11
12	20	Advertising & Promotions		58,973,306	231			6,852,411		12
13	25	Transportation		58,973,306	231	9,075		6,852,411	1,054	13
14	35	Car Rental		58,973,306	231	1,568		6,852,411	182	14
15	24	Conferences & Conventions		58,973,306	231	40,104		6,852,411	4,660	15
16	20	Subscriptions, Dues, Awards		58,973,306	231	7,109		6,852,411	826	16
17	6	Furniture & Fixtures		58,973,306	231			6,852,411		17
18	6	Machinery & Equipment		58,973,306	231			6,852,411		18
19	35	Equipment Rental		58,973,306	231			6,852,411		19
20	6	Equipment Repair & Maint.		58,973,306	231	14,199		6,852,411	1,650	20
21	20	Employee Recruitment		58,973,306	231	99,292		6,852,411	11,537	21
22	7	Security & Waste Removal		58,973,306	231	46		6,852,411	5	22
23	21	All Other Miscellaneous		58,973,306	231	745		6,852,411	87	23
24	30	Depreciation		58,973,306	231	60,946		6,852,411	7,082	24
25	TOTALS					$ 1,996,114	$ 1,018,059		$ 231,939	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	7,856,166	22	$ 253,168	$ 253,168	3,378,086	$ 108,860	1
2	22	Empl Benefits & Taxes		7,856,166	22	48,667		3,378,086	20,926	2
3	19	Prof Fees & Contracts		7,856,166	22	21,674		3,378,086	9,320	3
4	21	Supplies, Telephone,		7,856,166	22	3,610		3,378,086	1,552	4
5		Postage, Out. Printing		7,856,166	22			3,378,086		5
6	34	Rental of Space		7,856,166	22			3,378,086		6
7	5	Utilities		7,856,166	22			3,378,086		7
8	6	Bldg Repairs & Maintenance		7,856,166	22			3,378,086		8
9	32	Interest		7,856,166	22	11,000		3,378,086	4,730	9
10	33	Real Estate Taxes		7,856,166	22			3,378,086		10
11	26	Insurance		7,856,166	22	535		3,378,086	230	11
12	20	Advertising & Promotions		7,856,166	22	952		3,378,086	409	12
13	25	Transportation		7,856,166	22	10,975		3,378,086	4,719	13
14	35	Car Rental		7,856,166	22			3,378,086		14
15	24	Conferences & Conventions		7,856,166	22	3,595		3,378,086	1,546	15
16	20	Subscriptions, Dues, Awards		7,856,166	22	250		3,378,086	107	16
17	6	Furniture & Fixtures		7,856,166	22			3,378,086		17
18	6	Machinery & Equipment		7,856,166	22			3,378,086		18
19	35	Equipment Rental		7,856,166	22	883		3,378,086	380	19
20	6	Equipment Repair & Maint.		7,856,166	22			3,378,086		20
21	20	Employee Recruitment		7,856,166	22	81		3,378,086	35	21
22	7	Security & Waste Removal		7,856,166	22			3,378,086		22
23	21	All Other Miscellaneous		7,856,166	22			3,378,086		23
24	30	Depreciation		7,856,166	22	4,109		3,378,086	1,767	24
25	TOTALS					$ 359,499	$ 253,168		$ 154,582	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		X	Refinance Bldg. Additions		2/16/06	$ 3,752,000	$ 3,300,822	2/16/028/	0.0523	$ 167,315	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Allocation LSSI (Schedule VIII)		X								13,511	6
7												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												11
12												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.)**

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St. Matthew Center For Health **#** 0013896 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

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

B. Real Estate Taxes

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

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006		8
	2007		9
	2008		10
	2009		11
	2010		12

N/A

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

NOTES:

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

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.

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

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Matthew Center For Health COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013896

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the 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: 07/01/10 Ending: 06/30/11

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

None

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

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140		1959	1959	$ 444,500	$	40	$	$	$ 444,500	4
5			1966	1966	315,066		40			315,066	5
6			1976	1976	2,205,040		40	55,126	55,126	1,956,530	6
7			1976	1976	24,547		40	614	614	21,494	7
8			1977	1977	13,438		40	336	336	11,588	8
	Improvement Type**										
9	Various			1978	1,780		20			1,780	9
10	Various			1979	5,380		20			5,380	10
11	Various			1983	152,321		20			152,321	11
12	Various			1984	11,139		20			11,139	12
13	Various			1985	2,400		20			2,400	13
14	Various			1986	7,692		20			7,692	14
15	Various			1987	291,787		20			291,787	15
16	Various			1988	14,914		20			14,914	16
17	Various			1989	253,333		20			253,333	17
18	Various			1990	20,850		20			19,450	18
19	Various			1992	130,569		20			121,369	19
20	Various			1993	453,424		20			453,424	20
21	Various			1994	82,338		20			82,338	21
22	Various			1995	38,246		20			38,246	22
23	Various			1996	5,548		20			5,548	23
24	Various			1997	23,913		20			21,284	24
25	Various			1998	249,986		20	6,828	6,828	165,837	25
26	Various			1999	140,442		20	18	18	135,256	26
27	Various			2000	513,608		20	515	515	330,780	27
28	Various			2001	1,053,653		20	43,626	43,626	524,745	28
29	Various			2002	112,800		20	11,280	11,280	103,530	29
30	Various			2003	87,810		20	8,782	8,782	70,570	30
31	Various			2004	116,001		20	7,361	7,361	51,703	31
32	Various			2005	595,633		20	29,995	29,995	180,524	32
33	Various			2006	221,398		20	11,070	11,070	58,613	33
34	Various			2007	602,652		20	30,334	30,334	130,801	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)			41,566			(41,566)		68
69	Financial Statement Depreciation			355,316			(355,316)		69
70	TOTAL (lines 4 thru 69)		$ 8,192,209	$ 396,882		$ 205,885	$ (190,998)	$ 5,983,940	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,192,209	$ 396,882		$ 205,885	$ (190,998)	$ 5,983,940	1
2	Window Treatments	2008	19,997		20	1,000	1,000	3,999	2
3	Painting	2008	15,730		20	787	787	3,146	3
4	Window Treatments	2008	56,989		20	2,849	2,849	8,548	4
5	Cubicle Curtains	2008	20,130		20	1,007	1,007	3,020	5
6	Removal Of Carpet/Abatement Process	2008	6,850		20	343	343	1,028	6
7	Storm Sewer Drainage Repairs	2008	12,985		20	649	649	1,948	7
8	Sewage Ejector Pumps	2009	12,850		20	643	643	1,928	8
9	Fire Alarm System	2009	5,833		20	292	292	875	9
10	Carpet For Rooms 17&20	2009	3,550		20	178	178	533	10
11	Painting	2009	3,678		20	184	184	552	11
12	Sewage Ejector Pump	2009	12,850		20	643	643	1,285	12
13	Nurse Call System Upgrade	2009	19,250		20	963	963	1,925	13
14	Plumbing	2009	4,860		20	243	243	486	14
15	Drain & Sewer Repair	2009	3,230		20	162	162	323	15
16	Bathroom Renovation-Demo, Plumbing, Electric, Hvac,Drywall, P	2009	349,257		20	17,463	17,463	34,926	16
17	Front Entrance Door	2010	11,544		20	577	577	1,154	17
18	Fire Alarm Upgrades	2010	24,768		20	1,238	1,238	2,477	18
19	Fire Alarm Upgrades	2010	6,102		20	305	305	610	19
20	Upgrade Lighting	2010	45,596		20	2,280	2,280	4,560	20
21	Pipe Insulation	2010	14,660		20	733	733	1,466	21
22	Painting	2010	2,544		20	127	127	254	22
23	Firedoor Between Kitchen & Dining Room	2010	3,100		20	155	155	155	23
24	Control Panel For Garbage Disposal	2010	4,050		20	203	203	203	24
25	50 Ton A/C Unit On East Bldg Roof	2010	44,153		20	2,208	2,208	2,208	25
26	Asbestos Abatement In Hallways & Rooms	2010	43,071		20	2,154	2,154	2,154	26
27	Parking Lot Expansion	2010	11,993		20	600	600	600	27
28	Wallpaper-West Building Renovation	2010	40,446		20	2,022	2,022	2,022	28
29	Flooring-Resident Rooms	2010	169,593		20	5,484	5,484	5,484	29
30	Resident Rooms Entry Doors	2010	4,570		20	229	229	229	30
31	Repairs To Rooftop Energy Recovery	2011	6,184		20	309	309	309	31
32	100 Galon Water Heater-Kitchen & Laundry	2011	14,630		20	732	732	732	32
33	Fan Coil Units	2011	72,500		20	3,625	3,625	3,625	33
34	TOTAL (lines 1 thru 33)		$ 9,259,751	$ 396,882		$ 256,266	$ (140,616)	$ 6,076,701	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,259,751	$ 396,882		$ 256,266	$ (140,616)	$ 6,076,701	1
2	Flooring -Removal Of Asbestos	2011	13,770		20	689	689	689	2
3	Flooring-West Bldg Nurses Stations, Resident Rooms/Corridors	2011	42,511		20	2,126	2,126	2,126	3
4	Closet & Batheroom Doors-Resident Rooms	2011	18,377		20	919	919	919	4
5	Remove & Replace Broken Pipes	2011	4,190		20	210	210	210	5
6	Painting & Decorating	2011	5,664		20	283	283	283	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)		$ 9,344,263	$ 396,882		$ 260,492	$ (136,390)	$ 6,080,926	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 9,344,263	$ 396,882		$ 260,492	$ (136,390)	$ 6,080,926	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)		$ 9,344,263	$ 396,882		$ 260,492	$ (136,390)	$ 6,080,926	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		$ 9,344,263	$ 396,882		$ 260,492	$ (136,390)	$ 6,080,926	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)		$ 9,344,263	$ 396,882		$ 260,492	$ (136,390)	$ 6,080,926	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$	$		$	$	$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10	Allocation from LSSI			41,566			(41,566)		10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information Continued								1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$	$ 41,566		$	$ (41,566)	$	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: 07/01/10 Ending: 06/30/11

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 1,865,545	$	$ 153,668	$ 153,668	10	$ 1,487,644	71
72	Current Year Purchases	40,281		4,028	4,028	10	4,028	72
73	Fully Depreciated Assets	387,278				10	387,278	73
74								74
75	TOTALS	$ 2,293,104	$	$ 157,697	$ 157,697		$ 1,878,951	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,676,071	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 396,882	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 418,189	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,306	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 7,959,877	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Pickup Truck - 1900	$ 25,994	$ 1,415	$ 25,994	86
87	Bus - 1900	46,598	6,654	44,063	87
88	Coountertops for Rainbow Hospice - 2011	2,648	132	132	88
89					89
90					90
91	TOTALS	$ 75,240	$ 8,201	$ 70,189	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation LSSI (Schedule VIII)				45,586			5
6								6
7	TOTAL				$ 45,586 **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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
(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 (Schedule VIII)		$	$ 447	17
18					18
19					19
20					20
21	TOTAL		$	$ 447	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 317,600	$		$ 317,600	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			176,794			176,794	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			362,048			362,048	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			9,041			9,041	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				300,856		300,856	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					31,010	223,202		254,212	13
14	TOTAL			$		$ 896,493	$ 524,058		$ 1,420,551	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health **#** 0013896 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/11 **(last day of reporting year)**

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number St. Matthew Center For Health # 0013896 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

XVI. STATEMENT OF CHANGES IN EQUITY

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,452,224	1
2	Discounts and Allowances for all Levels	(347,700)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,104,524	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	353,923	6
7	Oxygen	8,231	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 362,154	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,100	13
14	Non-Patient Meals	43,944	14
15	Telephone, Television and Radio	385	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	158	20
21	Other Medical Services	(242)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 46,345	23
	D. Non-Operating Revenue		
24	Contributions	138,023	24
25	Interest and Other Investment Income***	5,395	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 143,418	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	550,159	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 550,159	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,206,600	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,875,672	31
32	Health Care	4,312,136	32
33	General Administration	3,252,374	33
	B. Capital Expense		
34	Ownership	536,024	34
	C. Ancillary Expense		
35	Special Cost Centers	1,618,898	35
36	Provider Participation Fee	76,650	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,671,754	40
41	**Income before Income Taxes (line 30 minus line 40)****	534,846	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 534,846	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: 07/01/10 Ending: 06/30/11

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,673	2,043	$ 84,507	$ 41.36	1
2	Assistant Director of Nursing	3,105	3,450	119,090	34.52	2
3	Registered Nurses	47,590	53,570	1,682,230	31.40	3
4	Licensed Practical Nurses	11,429	12,850	329,445	25.64	4
5	CNAs & Orderlies	104,061	116,058	1,431,424	12.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,613	1,963	32,870	16.74	9
10	Activity Assistants	15,823	17,319	201,844	11.65	10
11	Social Service Workers	4,405	5,325	94,712	17.79	11
12	Dietician					12
13	Food Service Supervisor	5,557	6,226	85,377	13.71	13
14	Head Cook	3,687	4,124	47,129	11.43	14
15	Cook Helpers/Assistants	29,272	32,193	305,350	9.48	15
16	Dishwashers					16
17	Maintenance Workers	7,440	8,477	140,934	16.63	17
18	Housekeepers	15,872	17,581	171,798	9.77	18
19	Laundry	7,155	7,856	72,437	9.22	19
20	Administrator	1,688	1,978	83,947	42.44	20
21	Assistant Administrator	2,917	3,279	102,917	31.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,962	22,033	349,078	15.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	11,192	12,406	200,020	16.12	33
34	TOTAL (lines 1 - 33)	293,441	328,731	$ 5,535,109 *	$ 16.84	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 149,068	01-03	35
36	Medical Director	As Needed	70,400	09-03	36
37	Medical Records Consultant	As Needed	2,920	10-03	37
38	Nurse Consultant	As Needed	7,195	10-03	38
39	Pharmacist Consultant	As Needed	8,301	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	264	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Chaplain	As Needed	36,481	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 274,629		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Steven St. Louis	Administrator		$ 83,947
Jonathan Moy	Assist. Administrator		52,780
Kelly Fitzgerald	Assist. Administrator		50,137
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 186,864

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Baker Tilly Virchow Krause, LLP	Accounting	$ 50,993
Debra Evertsen	Accounting	2,063
FR&R	Accounting	1,400
Qquest Software Systems	Computer Software	854
SWC Technology Partners, Inc.	Info System Consultant	3,970
LSSI	Management Services	903,288
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 962,568

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,722
Unemployment Compensation Insurance	26,640
FICA Taxes	403,523
Employee Health Insurance	537,657
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	11,831
Life Insurance	7,499
Pension	198,474
Other Benefits	910
LSSI Allocation (Schedule VIII)	107,990
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,425,247

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	7,936
(Indicate # of checks performed 496)	
Patient Background Checks	
Membership Dues	12,752
Subscriptions & Books	1,833
Licenses	436
Advertising	67,051
See Supplemental Schedule	15,157
Less: Public Relations Expense	( )
Non-allowable advertising	(67,051)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,114

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	40,178
LSSI Allocation (Schedule VIII)	10,108
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 50,286

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/10 Ending: 06/30/11

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health # 0013896 **Report Period Beginning:** 07/01/10 **Ending:** 06/30/11

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN - $5,290**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

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

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

(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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **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. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

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

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

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