

Facility Name & ID Number St. Matthew Center For Health

0013896 Report Period Beginning: 07/01/11 Ending: 06/30/12

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>101</u>	Skilled (SNF)	<u>101</u>	<u>36,966</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>39</u>	Intermediate (ICF)	<u>39</u>	<u>14,274</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>140</u>	TOTALS	<u>140</u>	<u>51,240</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>13,443</u>	<u>16,697</u>	<u>6,826</u>	<u>36,966</u>		8
9	SNF/PED						9
10	ICF		<u>8,032</u>		<u>8,032</u>		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	<u>13,443</u>	<u>24,729</u>	<u>6,826</u>	<u>44,998</u>		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.82%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 51 and days of care provided 6,597

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2012 Fiscal Year: 06/30/2012

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

Facility Name & ID Number St. Matthew Center For Health # 0013896 Report Period Beginning: 07/01/11 Ending: 06/30/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	427,851	52,560	156,970	637,381		637,381		637,381		1
2	Food Purchase		428,680		428,680		428,680	(73,408)	355,272		2
3	Housekeeping	143,735	41,905		185,640		185,640		185,640		3
4	Laundry	90,759	17,673	3,761	112,193		112,193		112,193		4
5	Heat and Other Utilities			178,595	178,595		178,595	1,813	180,408		5
6	Maintenance	138,675	17,908	179,863	336,446		336,446	25,714	362,160		6
7	Other (specify):*							2,344	2,344		7
8	TOTAL General Services	801,020	558,726	519,189	1,878,935		1,878,935	(43,537)	1,835,398		8
	B. Health Care and Programs										
9	Medical Director			74,400	74,400		74,400		74,400		9
10	Nursing and Medical Records	3,739,092	101,651	41,304	3,882,047		3,882,047	(4,228)	3,877,819		10
10a	Therapy										10a
11	Activities	276,799	43,478	2,144	322,421		322,421		322,421		11
12	Social Services	193,639		37,593	231,232		231,232		231,232		12
13	CNA Training										13
14	Program Transportation			1,250	1,250		1,250		1,250		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,209,530	145,129	156,691	4,511,350		4,511,350	(4,228)	4,507,122		16
	C. General Administration										
17	Administrative	104,537			104,537		104,537	562,069	666,606		17
18	Directors Fees										18
19	Professional Services			1,146,780	1,146,780		1,146,780	(897,120)	249,660		19
20	Dues, Fees, Subscriptions & Promotions			98,906	98,906		98,906	(51,816)	47,090		20
21	Clerical & General Office Expenses	367,014	98,251	61,423	526,688		526,688	14,799	541,487		21
22	Employee Benefits & Payroll Taxes			1,344,786	1,344,786		1,344,786	115,729	1,460,515		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,843	8,843		8,843	9,437	18,280		24
25	Other Admin. Staff Transportation			4,995	4,995		4,995	10,754	15,749		25
26	Insurance-Prop.Liab.Malpractice			148,628	148,628		148,628	12,544	161,172		26
27	Other (specify):*										27
28	TOTAL General Administration	471,551	98,251	2,814,361	3,384,163		3,384,163	(223,604)	3,160,559		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,482,101	802,106	3,490,241	9,774,448		9,774,448	(271,369)	9,503,079		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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			385,925	385,925		385,925	(54,715)	331,210			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			162,847	162,847		162,847	14,951	177,798			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							50,167	50,167			34
35	Rent-Equipment & Vehicles			1,813	1,813		1,813	1,411	3,224			35
36	Other (specify):*			4,256	4,256		4,256		4,256			36
37	TOTAL Ownership			554,841	554,841		554,841	11,814	566,655			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		551,359	865,786	1,417,145		1,417,145		1,417,145			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			368,920	368,920		368,920		368,920			42
43	Other (specify):*	71,070	20,205	60,059	151,334		151,334	(151,334)				43
44	TOTAL Special Cost Centers	71,070	571,564	1,294,765	1,937,399		1,937,399	(151,334)	1,786,065			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,553,171	1,373,670	5,339,847	12,266,688		12,266,688	(410,889)	11,855,799			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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(73,408)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(88,309)	30		9
10	Interest and Other Investment Income	(685)	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	(100)	21		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	(66,849)	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	(181,504)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (410,855)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(34)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (34)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (410,889)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

BHF USE ONLY							
48		49		50		51	52

St. Matthew Center For Health

ID# 0013896
 Report Period Beginning: 07/01/11
 Ending: 06/30/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Care Depreciation	\$ (2,667)	30	1
2	Additional R&M	24,497	06	2
3	Finance Charge	(872)	21	3
4	Sales to Public	(893)	21	4
5	Insurance Reimbursement	(3,215)	26	5
6	Clothing & Personal Supplies	(4,228)	10	6
7	Bank Service Charge	(145)	21	7
8	Marketing Salaries	(12,623)	43	8
9	Capitalized R&M	(14,813)	06	9
10	Expenses related to unrelated Hospice Co.	(138,711)	43	10
11	Gain/ Loss on Fixed Assets	(474)	21	11
12	Health Trust Rebate	(27,360)	21	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	(181,504)		49

St. Matthew Center For Health

Report Period Beginning: 07/01/11
 Ending: 06/30/12

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:

07/01/11

Ending:

06/30/12

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	(73,408)											(73,408)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,813									1,813	5
6	Maintenance	9,684		14,495	1,526	9							25,714	6
7	Other (specify):*			2,342	2								2,344	7
8	TOTAL General Services	(63,724)		18,650	1,528	9							(43,537)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,228)											(4,228)	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	(4,228)											(4,228)	16
	C. General Administration													
17	Administrative			317,532	114,808	129,729							562,069	17
18	Directors Fees													18
19	Professional Services			(549,786)	(174,269)	(173,065)							(897,120)	19
20	Fees, Subscriptions & Promotions	(66,849)		3,067	10,466	1,500							(51,816)	20
21	Clerical & General Office Expenses	(29,844)		33,186	9,544	1,913							14,799	21
22	Employee Benefits & Payroll Taxes			61,965	26,894	26,870							115,729	22
23	Inservice Training & Education													23
24	Travel and Seminar			3,160	4,809	1,468							9,437	24
25	Other Admin. Staff Transportation			7,747	953	2,054							10,754	25
26	Insurance-Prop.Liab.Malpractice	(3,215)		15,044	443	272							12,544	26
27	Other (specify):*													27
28	TOTAL General Administration	(99,908)		(108,085)	(6,352)	(9,259)							(223,604)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(167,860)		(89,435)	(4,824)	(9,250)							(271,369)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

07/01/11

Ending:

06/30/12

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(90,976)		32,024	1,044	3,193							(54,715)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(685)		8,595	994	6,047							14,951	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			47,470	2,697								50,167	34
35	Rent-Equipment & Vehicles			1,339	72								1,411	35
36	Other (specify):*													36
37	TOTAL Ownership	(91,661)		89,428	4,807	9,240							11,814	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):*	(151,334)											(151,334)	43
44	TOTAL Special Cost Centers	(151,334)											(151,334)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(410,855)		(7)	(17)	(10)							(410,889)	45

Facility Name & ID Number

St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending:

06/30/12

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
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Salaries & Wages	\$	Lutheran Social Services of Illinois - Management Allocation	100.00%	\$ 317,532	\$ 317,532	15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Management Allocation	100.00%	61,965	61,965	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Management Allocation	100.00%	8,882	8,882	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Management Allocation	100.00%	19,772	19,772	18
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Management Allocation	100.00%	47,470	47,470	19
20	V	5 Utilities		Lutheran Social Services of Illinois - Management Allocation	100.00%	1,813	1,813	20
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Management Allocation	100.00%	128	128	21
22	V	32 Interest		Lutheran Social Services of Illinois - Management Allocation	100.00%	8,595	8,595	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%	15,044	15,044	24
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois - Management Allocation	100.00%	(36)	(36)	25
26	V	25 Transportation		Lutheran Social Services of Illinois - Management Allocation	100.00%	7,747	7,747	26
27	V	35 Car Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	714	714	27
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Management Allocation	100.00%	3,160	3,160	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Management Allocation	100.00%	3,103	3,103	29
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Management Allocation	100.00%			30
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Management Allocation	100.00%			31
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Management Allocation	100.00%	625	625	32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Management Allocation	100.00%	14,367	14,367	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%	2,342	2,342	35
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Management Allocation	100.00%	13,414	13,414	36
37	V	30 Depreciation		Lutheran Social Services of Illinois - Management Allocation	100.00%	32,024	32,024	37
38	V	19 Management Allocation	558,668	Lutheran Social Services of Illinois - Management Allocation	100.00%		(558,668)	38
39	Total		\$ 558,668			\$ 558,661	\$ * (7)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Salaries & Wages	\$	Lutheran Social Services of Illinois - Human Resources Allocation		\$ 114,808	\$ 114,808
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Human Resources Allocation		26,894	26,894
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Human Resources Allocation		46,859	46,859
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Human Resources Allocation		4,757	4,757
19	V	34 Rental of Space		Lutheran Social Services of Illinois - Human Resources Allocation		2,697	2,697
20	V	5 Utilities		Lutheran Social Services of Illinois - Human Resources Allocation			
21	V	6 Bldg Repairs & Maintenance		Lutheran Social Services of Illinois - Human Resources Allocation			
22	V	32 Interest		Lutheran Social Services of Illinois - Human Resources Allocation		994	994
23	V	33 Real Estate Taxes		Lutheran Social Services of Illinois - Human Resources Allocation			
24	V	26 Insurance		Lutheran Social Services of Illinois - Human Resources Allocation		443	443
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois - Human Resources Allocation			
26	V	25 Transportation		Lutheran Social Services of Illinois - Human Resources Allocation		953	953
27	V	35 Car Rental		Lutheran Social Services of Illinois - Human Resources Allocation		72	72
28	V	24 Conferences & Conventions		Lutheran Social Services of Illinois - Human Resources Allocation		4,809	4,809
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Human Resources Allocation		872	872
30	V	6 Furniture & Fixtures		Lutheran Social Services of Illinois - Human Resources Allocation			
31	V	6 Machinery & Equipment		Lutheran Social Services of Illinois - Human Resources Allocation			
32	V	35 Equipment Rental		Lutheran Social Services of Illinois - Human Resources Allocation			
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Human Resources Allocation		1,526	1,526
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Human Resources Allocation		9,594	9,594
35	V	7 Security & Waste Removal		Lutheran Social Services of Illinois - Human Resources Allocation		2	2
36	V	21 All Other Miscellaneous		Lutheran Social Services of Illinois - Human Resources Allocation		4,787	4,787
37	V	30 Depreciation		Lutheran Social Services of Illinois - Human Resources Allocation		1,044	1,044
38	V	19 Human Resource Allocation	221,128	Lutheran Social Services of Illinois - Human Resources Allocation			(221,128)
39	Total		\$ 221,128			\$ 221,111	\$ * (17)

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 Salaries & Wages	\$	Lutheran Social Services of Illinois - Service Network Allocation	100.00%	\$ 129,729	\$	129,729	15
16	V	22 Empl Benefits & Taxes		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	26,870		26,870	16
17	V	19 Prof Fees & Contracts		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	13,925		13,925	17
18	V	21 Supplies, Telephone,		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	1,913		1,913	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%	6,047		6,047	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%	272		272	24
25	V	20 Advertising & Promotions		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	46		46	25
26	V	25 Transportation		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	2,054		2,054	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%	1,468		1,468	28
29	V	20 Subscriptions, Dues, Awards		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	1,454		1,454	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%				32
33	V	6 Equipment Repair & Maint.		Lutheran Social Services of Illinois - Service Network Allocation	100.00%	9		9	33
34	V	20 Employee Recruitment		Lutheran Social Services of Illinois - Service Network Allocation	100.00%				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%	3,193		3,193	37
38	V	19 Service Network Allocation	186,990	Lutheran Social Services of Illinois - Service Network Allocation	100.00%			(186,990)	38
39	Total		\$ 186,990			\$ 186,980	\$ *	(10)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES

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	LSSI	100.000%	P.A Peterson Center for Health	Rockford, IL	VESPER MANAGEMENT	DES PLAINES	MANAGEMENT CO.	1
2					LUTHERAN SOCIAL SERVICES	DES PLAINES	CORPORATE OFFICE	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

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: 07/01/11 Ending: 06/30/12

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Salaries & Wages	Non-Capital Direct Costs	36,642,160	269	\$ 3,150,086	\$ 3,150,086	3,693,567	\$ 317,532	1
2	22	Empl Benefits & Taxes		36,642,160	269	614,727	3,693,567	61,965		2
3	19	Prof Fees & Contracts		36,642,160	269	88,117	3,693,567	8,882		3
4	21	Supplies, Telephone,		36,642,160	269	196,147	3,693,567	19,772		4
5		Postage, Out. Printing		36,642,160	269		3,693,567			5
6	34	Rental of Space		36,642,160	269	470,928	3,693,567	47,470		6
7	5	Utilities		36,642,160	269	17,981	3,693,567	1,813		7
8	6	Bldg Repairs & Maintenance		36,642,160	269	1,271	3,693,567	128		8
9	32	Interest		36,642,160	269	85,265	3,693,567	8,595		9
10	33	Real Estate Taxes		36,642,160	269		3,693,567			10
11	26	Insurance		36,642,160	269	149,241	3,693,567	15,044		11
12	20	Advertising & Promotions		36,642,160	269	(360)	3,693,567	(36)		12
13	25	Transportation		36,642,160	269	76,850	3,693,567	7,747		13
14	35	Car Rental		36,642,160	269	7,081	3,693,567	714		14
15	24	Conferences & Conventions		36,642,160	269	31,352	3,693,567	3,160		15
16	20	Subscriptions, Dues, Awards		36,642,160	269	30,786	3,693,567	3,103		16
17	6	Furniture & Fixtures		36,642,160	269	3	3,693,567			17
18	6	Machinery & Equipment		36,642,160	269		3,693,567			18
19	35	Equipment Rental		36,642,160	269	6,204	3,693,567	625		19
20	6	Equipment Repair & Maint.		36,642,160	269	142,525	3,693,567	14,367		20
21	20	Employee Recruitment		36,642,160	269		3,693,567			21
22	7	Security & Waste Removal		36,642,160	269	23,233	3,693,567	2,342		22
23	21	All Other Miscellaneous		36,642,160	269	133,071	3,693,567	13,414		23
24	30	Depreciation		36,642,160	269	317,699	3,693,567	32,024		24
25	TOTALS					\$ 5,542,207	\$ 3,150,086		\$ 558,661	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	60,293,424	269	\$ 1,003,501	\$ 1,003,501	6,898,013	\$ 114,808	1
2	22	Empl Benefits & Taxes	60,293,424	269	235,075		6,898,013	26,894	2
3	19	Prof Fees & Contracts	60,293,424	269	409,579		6,898,013	46,859	3
4	21	Supplies, Telephone,	60,293,424	269	41,579		6,898,013	4,757	4
5		Postage, Out. Printing	60,293,424	269			6,898,013		5
6	34	Rental of Space	60,293,424	269	23,578		6,898,013	2,697	6
7	5	Utilities	60,293,424	269			6,898,013		7
8	6	Bldg Repairs & Maintenance	60,293,424	269			6,898,013		8
9	32	Interest	60,293,424	269	8,692		6,898,013	994	9
10	33	Real Estate Taxes	60,293,424	269			6,898,013		10
11	26	Insurance	60,293,424	269	3,872		6,898,013	443	11
12	20	Advertising & Promotions	60,293,424	269			6,898,013		12
13	25	Transportation	60,293,424	269	8,326		6,898,013	953	13
14	35	Car Rental	60,293,424	269	627		6,898,013	72	14
15	24	Conferences & Conventions	60,293,424	269	42,031		6,898,013	4,809	15
16	20	Subscriptions, Dues, Awards	60,293,424	269	7,625		6,898,013	872	16
17	6	Furniture & Fixtures	60,293,424	269			6,898,013		17
18	6	Machinery & Equipment	60,293,424	269			6,898,013		18
19	35	Equipment Rental	60,293,424	269			6,898,013		19
20	6	Equipment Repair & Maint.	60,293,424	269	13,335		6,898,013	1,526	20
21	20	Employee Recruitment	60,293,424	269	83,861		6,898,013	9,594	21
22	7	Security & Waste Removal	60,293,424	269	20		6,898,013	2	22
23	21	All Other Miscellaneous	60,293,424	269	41,840		6,898,013	4,787	23
24	30	Depreciation	60,293,424	269	9,123		6,898,013	1,044	24
25	TOTALS				\$ 1,932,664	\$ 1,003,501		\$ 221,111	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Salaries & Wages	Non-Capital Direct Costs	8,644,385	25	\$ 303,617	\$ 303,617	3,693,567	\$ 129,729	1
2	22	Empl Benefits & Taxes		8,644,385	25	62,887	3,693,567		26,870	2
3	19	Prof Fees & Contracts		8,644,385	25	32,590	3,693,567		13,925	3
4	21	Supplies, Telephone,		8,644,385	25	4,476	3,693,567		1,913	4
5		Postage, Out. Printing		8,644,385	25		3,693,567			5
6	34	Rental of Space		8,644,385	25		3,693,567			6
7	5	Utilities		8,644,385	25		3,693,567			7
8	6	Bldg Repairs & Maintenance		8,644,385	25		3,693,567			8
9	32	Interest		8,644,385	25	14,153	3,693,567		6,047	9
10	33	Real Estate Taxes		8,644,385	25		3,693,567			10
11	26	Insurance		8,644,385	25	636	3,693,567		272	11
12	20	Advertising & Promotions		8,644,385	25	108	3,693,567		46	12
13	25	Transportation		8,644,385	25	4,807	3,693,567		2,054	13
14	35	Car Rental		8,644,385	25		3,693,567			14
15	24	Conferences & Conventions		8,644,385	25	3,436	3,693,567		1,468	15
16	20	Subscriptions, Dues, Awards		8,644,385	25	3,403	3,693,567		1,454	16
17	6	Furniture & Fixtures		8,644,385	25		3,693,567			17
18	6	Machinery & Equipment		8,644,385	25		3,693,567			18
19	35	Equipment Rental		8,644,385	25		3,693,567			19
20	6	Equipment Repair & Maint.		8,644,385	25	21	3,693,567		9	20
21	20	Employee Recruitment		8,644,385	25		3,693,567			21
22	7	Security & Waste Removal		8,644,385	25		3,693,567			22
23	21	All Other Miscellaneous		8,644,385	25		3,693,567			23
24	30	Depreciation		8,644,385	25	7,474	3,693,567		3,193	24
25	TOTALS					\$ 437,608	\$ 303,617		\$ 186,980	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896 Report Period Beginning: 07/01/11 Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending: 06/30/12

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending:

06/30/12

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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1	Tax Exempt Bonds		X	Refinance Bldg. Additions		2/16/2006	\$ 3,752,000	\$ 3,193,890	2/16/2028	0.0523	\$ 162,848	1							
2												2							
3												3							
4												4							
5	See Supplemental Schedule											5							
	Working Capital																		
6												6							
7												7							
8	See Supplemental Schedule											8							
9	TOTAL Facility Related						\$ 3,752,000	\$ 3,193,890			\$ 162,848	9							
	B. Non-Facility Related*																		
10	Interest Income		X								(685)	10							
11	Allocation LSSI (Schedule VIII)		X								15,635	11							
12												12							
13	See Supplemental Schedule											13							
14	TOTAL Non-Facility Related						\$	\$			\$ 14,950	14							
15	TOTALS (line 9+line14)						\$ 3,752,000	\$ 3,193,890			\$ 177,798	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:

07/01/11

Ending:

06/30/12

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

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

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

(See instructions.)

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.)

2011 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 2011 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 2011.

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

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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.**

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending:

06/30/12

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

None

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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	2,011,656	6
7		1976	1976	24,547		40	614	614	22,108	7
8		1977	1977	13,438		40	336	336	11,924	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	172,664	25
26	Various		1999	140,442		20	18	18	135,274	26
27	Various		2000	513,608		20	131	131	330,911	27
28	Various		2001	1,053,653		20	37,712	37,712	562,403	28
29	Various		2002	112,800		20	10,767	10,767	114,297	29
30	Various		2003	87,810		20	8,782	8,782	79,352	30
31	Various		2004	116,001		20	7,361	7,361	59,064	31
32	Various		2005	595,633		20	29,998	29,998	210,525	32
33	Various		2006	221,398		20	11,071	11,071	69,686	33
34	Various		2007	602,652		20	30,333	30,333	161,135	34
35	Various		2008	132,681		20	6,635	6,635	28,324	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
Related Building Company (Pages 12F & 12G)								
Related Party Allocations (Pages 12H & 12I)								
Financial Statement Depreciation								
TOTAL (lines 4 thru 69)		\$ 8,324,890	\$ 419,519		\$ 205,712	\$ (213,807)	\$ 6,211,294	

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:

07/01/11

Ending:

06/30/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,324,890	\$ 419,519		\$ 205,712	\$ (213,807)	\$ 6,211,294	1
2	Sewage Ejector Pumps	2009	12,850		20	643	643	2,571	2
3	Fire Alarm System	2009	5,833		20	292	292	1,167	3
4	Carpet For Rooms 17&20	2009	3,550		20	178	178	711	4
5	Painting	2009	3,678		20	184	184	736	5
6	Sewage Ejector Pump	2009	12,850		20	643	643	1,928	6
7	Nurse Call System Upgrade	2009	19,250		20	963	963	2,888	7
8	Plumbing	2009	4,860		20	243	243	729	8
9	Drain & Sewer Repair	2009	3,230		20	162	162	485	9
10	Bathroom Renovation-Demo, Plumbing, Electric, Hvac,Drywall, P	2009	349,257		20	17,463	17,463	52,389	10
11	Front Entrance Door	2010	11,544		20	577	577	1,731	11
12	Fire Alarm Upgrades	2010	24,768		20	1,238	1,238	3,715	12
13	Fire Alarm Upgrades	2010	6,102		20	305	305	915	13
14	Upgrade Lighting	2010	45,596		20	2,280	2,280	6,840	14
15	Pipe Insulation	2010	14,660		20	733	733	2,199	15
16	Painting	2010	2,544		20	127	127	381	16
17	Firedoor Between Kitchen & Dining Room	2010	3,100		20	155	155	310	17
18	Control Panel For Garbage Disposal	2010	4,050		20	203	203	406	18
19	50 Ton A/C Unit On East Bldg Roof	2010	44,153		20	2,208	2,208	4,416	19
20	Asbestos Abatement In Hallways & Rooms	2010	43,071		20	2,154	2,154	4,308	20
21	Parking Lot Expansion	2010	11,993		20	600	600	1,200	21
22	Wallpaper-West Building Renovation	2010	40,446		20	2,022	2,022	4,044	22
23	Flooring-Resident Rooms	2010	169,593		20	5,484	5,484	10,968	23
24	Resident Rooms Entry Doors	2010	4,570		20	229	229	458	24
25	Repairs To Rooftop Energy Recovery	2011	6,184		20	309	309	618	25
26	100 Galon Water Heater-Kitchen & Laundry	2011	14,630		20	732	732	1,464	26
27	Fan Coil Units	2011	72,500		20	3,625	3,625	7,250	27
28	Flooring -Removal Of Asbestos	2011	13,770		20	689	689	1,378	28
29	Flooring-West Bldg Nurses Stations, Resident Rooms/Corridors	2011	42,511		20	2,126	2,126	4,252	29
30	Closet & Bathroom Doors-Resident Rooms	2011	18,377		20	919	919	1,838	30
31	Remove & Replace Broken Pipes	2011	4,190		20	210	210	420	31
32	Painting & Decorating	2011	5,664		20	283	283	566	32
33	Magnetic Door Lock	2011	13,300		20	665	665	665	33
34	TOTAL (lines 1 thru 33)		\$ 9,357,563	\$ 419,519		\$ 254,356	\$ (165,163)	\$ 6,335,240	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:

07/01/11

Ending:

06/30/12

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,357,563	\$ 419,519		\$ 254,356	\$ (165,163)	\$ 6,335,240	1
2	Reception Desk	2011	9,760		20	488	488	488	2
3	Chiller Compressor	2011	10,127		20	506	506	506	3
4	Fan Coil Units - East Wing	2011	22,193		20	1,110	1,110	1,110	4
5	Boiler	2011	18,467		20	923	923	923	5
6	6 Fan Coil Units	2011	12,480		20	624	624	624	6
7	Boiler	2011	18,468		20	923	923	923	7
8	Grease Trap	2011	2,900		20	145	145	145	8
9	Carpeting - Ground Floor Hall, Reception Area	2011	6,641		20	332	332	332	9
10	Flooring -Resident Rooms, Rec Room	2011	22,021		20	1,101	1,101	1,101	10
11	Vinyl Flooring Room 222	2011	3,660		20	183	183	183	11
12	Tuckpointing	2011	64,850		20	3,243	3,243	3,243	12
13	Kitchen Floor	2011	18,355		20	918	918	918	13
14	Excavated And Repaired Broken Storm Drain	2011	4,831		20	242	242	242	14
15	Boiler Repair	2011	5,010		20	251	251	251	15
16	Grease Trap	2012	2,650		20	133	133	133	16
17	Flooring-Halls/Elevator, Lobby/Reception	2012	12,710		20	635	635	635	17
18	Exterior Soffit Renovation	2012	476,035		20	23,802	23,802	23,802	18
19	Sanitary Sewer Catch Basin/Sewer Pipes	2012	14,360		20	718	718	718	19
20	Cabling For Wireless Access	2012	55,674		20	2,784	2,784	2,784	20
21	Soffit Renovations-Exterior Overhang	2012	25,044		20	1,252	1,252	1,252	21
22	Painting - Various Residents Rooms	2012	4,972		20	249	249	249	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)		\$ 10,168,771	\$ 419,519		\$ 294,916	\$ (124,603)	\$ 6,375,800	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 10,168,771	\$ 419,519		\$ 294,916	\$ (124,603)	\$ 6,375,800	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)	\$ 10,168,771	\$ 419,519		\$ 294,916	\$ (124,603)	\$ 6,375,800	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 10,168,771	\$ 419,519		\$ 294,916	\$ (124,603)	\$ 6,375,800	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)	\$ 10,168,771	\$ 419,519		\$ 294,916	\$ (124,603)	\$ 6,375,800	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

Building Company Information Continued

TOTAL (12F & 12G lines 1 thru 33)

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

B. Building 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			36,260			(36,260)		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.

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)		\$	\$ 36,260		\$	\$ (36,260)	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

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	\$ 533,724	\$	\$ 36,293	\$ 36,293	10	\$ 127,369	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,787,881				10	1,787,881	73
74								74
75	TOTALS	\$ 2,321,605	\$	\$ 36,293	\$ 36,293		\$ 1,915,250	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)	\$ 12,529,080	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 419,519	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 331,210	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (88,309)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 8,291,051	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	\$	\$ 25,994	86
87	Bus - 1900	46,598	2,535	46,598	87
88	Countertops for Rainbow Hospice - 2011	2,648	132	264	88
89					89
90					90
91	TOTALS	\$ 75,240	\$ 2,667	\$ 72,856	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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)				50,167			5
6								6
7	TOTAL				\$ 50,167			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: _____*

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

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

YES NO

16. Rental Amount for movable equipment: \$ 2,438 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)		\$ _____	\$ 786	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ 786	21

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. _____/2013 \$ _____

13. _____/2014 \$ _____

14. _____/2015 \$ _____

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			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	\$		\$	315,301	\$			\$	315,301	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				105,065					105,065	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				415,617					415,617	4	
5	Physician Care		visits										5	
6	Dental Care	39 - 03	visits				4,161					4,161	6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39 - 02	# of prescrpts						253,828			253,828	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify): <u>See Supplemental</u>						25,642		297,531			323,173	13	
14	TOTAL			\$		\$	865,786	\$	551,359	\$		1,417,145	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

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **06/30/12**

(last day of reporting year)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

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

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,081,510	1
2	Discounts and Allowances for all Levels	(375,968)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,705,542	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	518,679	6
7	Oxygen	7,227	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 525,906	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	2,400	13
14	Non-Patient Meals	73,408	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	5,458	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	156,096	21
22	Laundry	38	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 237,400	23
D. Non-Operating Revenue			
24	Contributions	161,865	24
25	Interest and Other Investment Income***	685	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 162,550	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	559,092	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 559,092	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,190,490	30

2		3	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,878,935	31
32	Health Care	4,511,350	32
33	General Administration	3,384,163	33
B. Capital Expense			
34	Ownership	554,841	34
C. Ancillary Expense			
35	Special Cost Centers	1,568,479	35
36	Provider Participation Fee	368,920	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,266,688	40
41	Income before Income Taxes (line 30 minus line 40)**	(76,198)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (76,198)	43

3		4	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,493,223	44
45	Private Pay - Net Inpatient Revenue	5,969,891	45
46	Medicare - Net Inpatient Revenue	3,242,428	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,705,542	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number St. Matthew Center For Health

0013896

Report Period Beginning:

07/01/11

Ending:

06/30/12

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,333	1,524	\$ 62,772	\$ 41.19	1
2	Assistant Director of Nursing	5,159	5,689	196,875	34.61	2
3	Registered Nurses	48,437	53,294	1,661,432	31.17	3
4	Licensed Practical Nurses	11,615	12,715	326,284	25.66	4
5	CNAs & Orderlies	111,619	122,898	1,491,729	12.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,783	3,444	61,454	17.84	9
10	Activity Assistants	17,484	18,667	215,345	11.54	10
11	Social Service Workers	4,654	5,123	92,061	17.97	11
12	Dietician					12
13	Food Service Supervisor	3,914	4,344	62,113	14.30	13
14	Head Cook	3,494	3,737	46,478	12.44	14
15	Cook Helpers/Assistants	33,147	34,756	319,260	9.19	15
16	Dishwashers					16
17	Maintenance Workers	7,549	8,304	138,675	16.70	17
18	Housekeepers	15,070	15,728	143,735	9.14	18
19	Laundry	8,664	9,001	90,759	10.08	19
20	Administrator	1,695	1,899	81,693	43.02	20
21	Assistant Administrator	797	903	22,844	25.30	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	20,632	22,394	367,014	16.39	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) <u>See Supplemental</u>	9,897	10,890	172,648	15.85	33
34	TOTAL (lines 1 - 33)	307,943	335,310	\$ 5,553,171 *	\$ 16.56	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	As Needed	\$ 156,970	01-03	35
36	Medical Director	As Needed	74,400	09-03	36
37	Medical Records Consultant	As Needed	3,080	10-03	37
38	Nurse Consultant	As Needed	8,518	10-03	38
39	Pharmacist Consultant	As Needed	29,706	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	2,144	11-03	44
45	Social Service Consultant		5	12-03	45
46	Other(specify)				46
47	<u>Chaplain</u>	As Needed	37,588	13-03	47
48					48
49	TOTAL (lines 35 - 48)		\$ 312,411		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	1	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# 0013896Report Period Beginning: 07/01/11Ending: 06/30/12**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 - \$5,598
- (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? N/A
- (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. \$ 44,331 Line 10-02
- (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. N/A
- (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. \$ 368,920
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 73,408
- (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? 100% line 14
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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT