

		FOR OHF USE				

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

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

<p><b>I. IDPH Facility ID Number:</b> <u>0013896</u></p> <p><b>Facility Name:</b> <u>St Matthew Lutheran Home</u></p> <p><b>Address:</b> <u>1601 N. Western Ave</u> <u>Park Ridge, Illinois</u> <u>60068</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(847) 825-5531</u> Fax # <u>(847) 318-6659</u></p> <p><b>IDPA ID Number:</b> <u>36-2584799-001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>1959</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> <u>501 (C) (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Dorkas Cruz</u> <b>Telephone Number:</b> <u>(847) 365-4633</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501 (C) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/01</u> to <u>06/30/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 678 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 678 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>Frederick Aigner</u></td> </tr> <tr> <td data-bbox="1144 828 1281 876"></td> <td data-bbox="1281 828 1921 876">(Title) <u>President</u></td> </tr> <tr> <td data-bbox="1144 876 1281 1039">Paid Preparer</td> <td data-bbox="1281 876 1921 1039">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) <u>( )</u> Fax # ( )</td> </tr> </table> <p align="center"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>      201 S. Grand Avenue East      Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Frederick Aigner</u>		(Title) <u>President</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																													
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																													
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	(Title) <u>President</u>																														
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )																														

Facility Name & ID Number St Matthew Lutheran Home

# 0013896 Report Period Beginning: 07/01/01 Ending: 06/30/02

**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 176

	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>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>56</u>	Intermediate (ICF)	<u>56</u>	<u>20,440</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>176</u>	TOTALS	<u>176</u>	<u>64,240</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 Public Aid Recipient	4 Private Pay	Other		
8	SNF		<u>25,036</u>	<u>4,988</u>	<u>30,024</u>	8
9	SNF/PED	<u>11,537</u>			<u>11,537</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,537</u>	<u>25,036</u>	<u>4,988</u>	<u>41,561</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.70%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 19 and days of care provided 4,988

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/02 Fiscal Year: 06/30/02

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

Facility Name &amp; ID Number

St Matthew Lutheran Home

# 0013896

Report Period Beginning:

07/01/01

Ending:

06/30/02

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	325,784	23,170	72,134	421,088		421,088		421,088		1
2	Food Purchase		236,584		236,584		236,584	(1,590)	234,994		2
3	Housekeeping	114,324	69,357		183,681		183,681		183,681		3
4	Laundry	53,726	26,806	71,506	152,038		152,038		152,038		4
5	Heat and Other Utilities			172,268	172,268	2,473	174,741		174,741		5
6	Maintenance	117,811	11,777	94,725	224,313	1,975	226,288		226,288		6
7	Other (specify):* Rubbish Removal			16,064	16,064	781	16,845		16,845		7
8	<b>TOTAL General Services</b>	611,645	367,694	426,697	1,406,036	5,229	1,411,265	(1,590)	1,409,675		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,700	14,700		14,700		14,700		9
10	Nursing and Medical Records	2,477,968	253,323	93,280	2,824,571		2,824,571		2,824,571		10
10a	Therapy	44,328		290,798	335,126		335,126		335,126		10a
11	Activities	38,848	2,494	16,369	57,711		57,711		57,711		11
12	Social Services	133,991	985	1,908	136,884		136,884		136,884		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Dentist			5,245	5,245		5,245		5,245		15
16	<b>TOTAL Health Care and Programs</b>	2,695,135	256,802	422,300	3,374,237		3,374,237		3,374,237		16
	<b>C. General Administration</b>										
17	Administrative	60,326			60,326	204,051	264,377		264,377		17
18	Directors Fees										18
19	Professional Services			515,343	515,343	(373,574)	141,769	140,460	282,229		19
20	Dues, Fees, Subscriptions & Promotions			16,185	16,185	24,253	40,438	(9,032)	31,406		20
21	Clerical & General Office Expenses	195,708	18,373	50,063	264,144	39,307	303,451		303,451		21
22	Employee Benefits & Payroll Taxes			750,455	750,455	16,317	766,772		766,772		22
23	Inservice Training & Education					3,230	3,230		3,230		23
24	Travel and Seminar			12,290	12,290		12,290	(189)	12,101		24
25	Other Admin. Staff Transportation					5,020	5,020		5,020		25
26	Insurance-Prop.Liab.Malpractice			40,996	40,996	12,962	53,958		53,958		26
27	Other (specify):* Marketing, Fundraisi	31,758			31,758	3,382	35,140	(35,140)			27
28	<b>TOTAL General Administration</b>	287,792	18,373	1,385,332	1,691,497	(65,052)	1,626,445	96,099	1,722,544		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,594,572	642,869	2,234,329	6,471,770	(59,823)	6,411,947	94,509	6,506,456		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Facility Name & ID Number St Matthew Lutheran Home #0013896 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			399,747	399,747	25,833	425,580	(430)	425,150			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			200,743	200,743	6,006	206,749	(42)	206,707			32
33	Real Estate Taxes					156	156		156			33
34	Rent-Facility & Grounds					22,852	22,852		22,852			34
35	Rent-Equipment & Vehicles			51,320	51,320	4,976	56,296		56,296			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			651,810	651,810	59,823	711,633	(472)	711,161			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			651	651		651		651			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,360	96,360		96,360		96,360			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			97,011	97,011		97,011		97,011			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,594,572	642,869	2,983,150	7,220,591		7,220,591	94,037	7,314,628			45

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

Facility Name & ID Number St Matthew Lutheran Home

# 0013896

Report Period Beginning: 07/01/01

Ending: 06/30/02

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,590)	2		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	1,438	30		9
10	Interest and Other Investment Income	(42)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(44,172)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	139,005			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 94,639		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	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
35	Other- Attach Schedule	(602)	30	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (602)		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)</b>	\$ 94,037		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

St Matthew Lutheran Home

ID# 0013896  
 Report Period Beginning: 07/01/01  
 Ending: 06/30/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Allowable Mgmt & HR Allocation	\$ 66,508	19	1
2	Allowable Serv. Network Allocation	73,952	19	2
3	Management Auto Depreciation	(1,266)	30	3
4	Prior Fiscal Year Travel	(189)	24	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	<b>Total</b>	139,005		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number St Matthew Lutheran Home

# 0013896 Report Period Beginning:

07/01/01

Ending:

06/30/02

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,590)	0	0	0	0	0	0	0	0	0	0	(1,590)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,590)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,590)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	140,460	0	0	0	0	0	0	0	0	0	0	140,460	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(189)	0	0	0	0	0	0	0	0	0	0	(189)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(44,172)	0	0	0	0	0	0	0	0	0	0	(44,172)	27
28	<b>TOTAL General Administration</b>	<b>96,099</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>96,099</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>94,509</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>94,509</b>	<b>29</b>



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A		Vesper Mgmt Corp. LSSI	Des Plaines, IL Des Plaines, IL	Mgmt Co. Corp. Office

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

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

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

Facility Name & ID Number      St Matthew Lutheran Home      #      0013896      Report Period Beginning:      07/01/01      Ending:      06/30/02

## 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									\$	1
2										2
3										3
4	N/A									4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Lutheran Social Services of Illinois  
 Street Address 1001 E. Touhy Ave Suite # 50  
 City / State / Zip Code Des Plaines, IL 60016  
 Phone Number ( 847) 635-4600  
 Fax Number ( 847) 635-6764

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	25,992,212	270	\$ 1,125,505	\$ 1,786,186	\$ 77,345	1
2	22	Empl Benefits & Taxes		25,992,212	270	(144,917)	1,786,186	(9,959)	2
3	19	Prof Fees & Contracts		25,992,212	270	3,524,353	1,786,186	242,194	3
4	21	Supplies, Telephone,		25,992,212	270	490,475	1,786,186	33,705	4
5		Postage, Out. Printing		25,992,212	270	0	1,786,186	0	5
6	34	Rental of Space		25,992,212	270	318,277	1,786,186	21,872	6
7	5	Utilities		25,992,212	270	35,381	1,786,186	2,431	7
8	6	Bldg Repairs & Maintenance		25,992,212	270	984	1,786,186	68	8
9	32	Interest		25,992,212	270	80,208	1,786,186	5,512	9
10	33	Real Estate Taxes		25,992,212	270	2,265	1,786,186	156	10
11	26	Insurance		25,992,212	270	186,098	1,786,186	12,789	11
12	27	Advertising & Promotions		25,992,212	270	44,994	1,786,186	3,092	12
13	25	Transportation		25,992,212	270	40,592	1,786,186	2,789	13
14	35	Car Rental		25,992,212	270	537	1,786,186	37	14
15	23	Conferences & Conventions		25,992,212	270	30,389	1,786,186	2,088	15
16	20	Subscriptions, Dues, Awards		25,992,212	270	32,258	1,786,186	2,217	16
17	21	Furniture & Fixtures		25,992,212	270	463	1,786,186	32	17
18	6	Machinery & Equipment		25,992,212	270	378	1,786,186	26	18
19	35	Equipment Rental		25,992,212	270	53,376	1,786,186	3,668	19
20	6	Equipment Repair & Maint.		25,992,212	270	23,734	1,786,186	1,631	20
21	20	Employee Recruitment		25,992,212	270	0	1,786,186	0	21
22	7	Security & Waste Removal		25,992,212	270	11,369	1,786,186	781	22
23	21	All Other Miscellaneous		25,992,212	270	5,351	1,786,186	368	23
24	30	Depreciation		25,992,212	270	346,548	1,786,186	23,815	24
25	TOTALS					\$ 6,208,618	\$ 1,125,505	\$ 426,657	25

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/01 Ending: 06/30/02

## VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Lutheran Social Services of Illinois  
 Street Address 1001 E. Touhy Ave Suite # 50  
 City / State / Zip Code Des Plaines, IL 60016  
 Phone Number ( 847) 635-4600  
 Fax Number ( 847) 635-6764

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/(col.4)x col.6)	
1	17	Salaries & Wages	46,042,289	244	\$ 928,620	\$ 928,620	4,345,027	\$ 87,634	1
2	22	Empl Benefits & Taxes	46,042,289	244	144,251		4,345,027	13,613	2
3	19	Prof Fees & Contracts	46,042,289	244	139,400		4,345,027	13,155	3
4	21	Supplies, Telephone, Postage, Out. Printing	46,042,289	244	31,083		4,345,027	2,933	4
5			46,042,289	244			4,345,027		5
6	34	Rental of Space	46,042,289	244	4,380		4,345,027	413	6
7	5	Utilities	46,042,289	244	445		4,345,027	42	7
8	6	Bldg Repairs & Maintenance	46,042,289	244	430		4,345,027	41	8
9	32	Interest	46,042,289	244	5,232		4,345,027	494	9
10	33	Real Estate Taxes	46,042,289	244			4,345,027		10
11	26	Insurance	46,042,289	244	1,831		4,345,027	173	11
12	27	Advertising & Promotions	46,042,289	244			4,345,027		12
13	25	Transportation	46,042,289	244	14,762		4,345,027	1,393	13
14	35	Car Rental	46,042,289	244	4,457		4,345,027	421	14
15	23	Conferences & Conventions	46,042,289	244	8,462		4,345,027	799	15
16	20	Subscriptions, Dues, Awards	46,042,289	244	173,188		4,345,027	16,344	16
17	21	Furniture & Fixtures	46,042,289	244	145		4,345,027	14	17
18	6	Machinery & Equipment	46,042,289	244			4,345,027		18
19	35	Equipment Rental	46,042,289	244	8,743		4,345,027	825	19
20	6	Equipment Repair & Maint.	46,042,289	244	2,211		4,345,027	209	20
21	20	Employee Recruitment	46,042,289	244	58,673		4,345,027	5,537	21
22	7	Security & Waste Removal	46,042,289	244			4,345,027		22
23	21	All Other Miscellaneous	46,042,289	244	375		4,345,027	35	23
24	30	Depreciation	46,042,289	244	13,468		4,345,027	1,271	24
25	<b>TOTALS</b>				\$ 1,540,156	\$ 928,620		\$ 145,346	25

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Lutheran Social Services of Illinois  
 Street Address 1001 E. Touhy Ave Suite # 50  
 City / State / Zip Code Des Plaines, IL 60016  
 Phone Number ( 847) 635-4600  
 Fax Number ( 847) 635-6764

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	2	\$ 84,305	\$ 84,305	1,786,186	\$ 39,072	1
2	22	Empl Benefits & Taxes		2	27,323		1,786,186	12,663	2
3	19	Prof Fees & Contracts		2	917		1,786,186	425	3
4	21	Supplies, Telephone,		2	2,086		1,786,186	967	4
5		Postage, Out. Printing		2			1,786,186		5
6	34	Rental of Space		2	1,224		1,786,186	567	6
7	5	Utilities		2			1,786,186		7
8	6	Bldg Repairs & Maintenance		2			1,786,186		8
9	32	Interest		2			1,786,186		9
10	33	Real Estate Taxes		2			1,786,186		10
11	26	Insurance		2			1,786,186		11
12	27	Advertising & Promotions		2	625		1,786,186	290	12
13	25	Transportation		2	1,809		1,786,186	838	13
14	35	Car Rental		2	53		1,786,186	25	14
15	23	Conferences & Conventions		2	740		1,786,186	343	15
16	20	Subscriptions, Dues, Awards		2	335		1,786,186	155	16
17	21	Furniture & Fixtures		2			1,786,186		17
18	6	Machinery & Equipment		2			1,786,186		18
19	35	Equipment Rental		2			1,786,186		19
20	6	Equipment Repair & Maint.		2			1,786,186		20
21	20	Employee Recruitment		2			1,786,186		21
22	7	Security & Waste Removal		2			1,786,186		22
23	21	All Other Miscellaneous		2	2,704		1,786,186	1,253	23
24	30	Depreciation		2	1,611		1,786,186	747	24
25	TOTALS				\$ 123,732	\$ 84,305		\$ 57,345	25

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 07/01/01 Ending: 06/30/02

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2	3	4	5	6		7	8	9	10									
						Name of Lender	Related**					Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES								NO	Original				Balance
	<b>A. Directly Facility Related</b>																			
	<b>Long-Term</b>																			
1	Tax Exempt Bonds		X	Refinance Building Additions	N/A	9/23/93	\$ 1,286,188	\$ 2,962,386	8/15/20	0.0738	\$ 200,743	1								
2												2								
3												3								
4												4								
5												5								
	<b>Working Capital</b>																			
6	Mgmt Allocation	X		Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	6,006	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 1,286,188	\$ 2,962,386			\$ 206,749	9								
	<b>B. Non-Facility Related*</b>																			
10												10								
11	Interest Income			Offset against Interest Expense	N/A	N/A	N/A	N/A	N/A	N/A	(42)	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ (42)	14								
15	TOTALS (line 9+line14)						\$ 1,286,188	\$ 2,962,386			\$ 206,707	15								

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

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

\*\* 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 Lutheran Home**# **0013896** Report Period Beginning: **07/01/01** Ending: **06/30/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																	
1.	Real Estate Tax accrual used on 2001 report.	\$	N/A		1														
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2														
3.	Under or (over) accrual (line 2 minus line 1).	\$			3														
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4														
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$			5														
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$			6														
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:		1997	8	<table border="1"> <tr> <td colspan="2"><b>FOR OHF USE ONLY</b></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2001 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>		<b>FOR OHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2001 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR OHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2001 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	1998	9																	
	1999	10																	
	2000	11																	
	2001	12																	

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME St Matthew Lutheran Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013896

CONTACT PERSON REGARDING THIS REPORT Dorkas Cruz

TELEPHONE (847) 635-4633 FAX #: (847) 635-6764

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 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 2001.

(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. <u>N/A</u>	<u>N/A</u>	<u>\$ N/A</u>	<u>\$ N/A</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		<u>\$ N/A</u>	<u>\$ N/A</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number St Matthew Lutheran Home# 0013896 Report Period Beginning:07/01/01 Ending:06/30/02

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,590 B. General Construction Type: Exterior Masonry Frame Steel Beam Number of Stories 2C. 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, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NoneF. 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	<b>TOTALS</b>	<b>203,354</b>		<b>\$ 38,704</b>	<b>3</b>

Facility Name &amp; ID Number St Matthew Lutheran Home

# 0013896

Report Period Beginning:

07/01/01

Ending:

06/30/02

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	176	1959	1959	\$ 444,500	\$	40	\$	\$	\$ 444,500
5		1966	1966	315,066	7,877	40	7,877		287,551
6		1976	1976	2,205,040	55,126	40	55,126		1,460,915
7		1976	1976	24,547	614	40	614		15,966
8		1977	1977	13,438	336	40	336		8,567
<b>Improvement Type**</b>									
9	1983 Addition		1983	150,179		10			150,179
10	1978 Addition		1978	1,780		10			1,780
11	1979 Addition		1979	5,380		10			5,380
12	1983 Addition		1983	2,142		10			2,142
13	1984 Addition		1984	11,139		10			11,139
14	1985 Addition		1985	2,400		10			2,400
15	1986 Addition		1986	7,692		10			7,692
16	1987 Addition		1987	291,787	14,589	20	14,589		226,155
17	Renovations		1989	268,451		10			268,451
18	ADJUSTMENT PER IDPA - 1989 Renovations		1989	(22,714)		10			(22,714)
19	ADJUSTMENT PER IDPA - 1988 Costs		1988	14,914		10			14,914
20	Aluminum Awning		1990	1,400		10			1,400
21	Canopy / Western ave.		1992	30,720	1,228	25	1,228		12,907
22	Panasonic Camera System		1992	3,720		5			3,720
23	New Sidewalk		1992	2,500	58	10	58		2,500
24	Concrete Loading dock		1992	6,690	246	10	246		6,690
25	Bathroom Remodeling		1992	13,440	1,344	10	1,344		12,774
26	Chapel Renovation		1992	33,385	3,338	10	3,338		31,720
27	Generator & Mechanical Work		1993	43,564	4,356	10	4,356		37,047
28	New Roof West Building		1993	208,807	20,881	10	20,881		177,572
29	Generator Project & electrical		1993	146,296	14,630	10	14,630		124,412
30	Upgrade West Building Electrical		1993	19,029	1,903	10	1,903		16,182
31	Alzheimer Unit		1992	40,114	4,011	10	4,011		34,113
32	Alzheimer Unit		1993	35,728	3,573	10	3,573		30,384
33	ADJUSTMENT PER IDPA - Alzheimer Unit		1993	(6,025)		10	(602)	(602)	(5,423)
34	ADJUSTMENT PER IDPA - 1990 Improvements OHF		1990	19,450		10			19,450
35	Parking Lot Lighting		1994	17,300	1,730	10	1,730		14,707
36	Shower Room Renovation		1994	9,455	945	10	945		7,095

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

See Page 12A, Line 70 for total

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

## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number St Matthew Lutheran Home

# 0013896

Report Period Beginning:

07/01/01

Ending:

06/30/02

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Rehab Area Renovation	1994	\$ 55,583	\$ 5,558	10	\$ 5,558	\$	\$ 41,710	37
38	Air Conditioning - West Bldg	1995	32,823	3,282	10	3,282		23,641	38
39	Air Conditioning Project - #95-056	1995	5,423	542	10	542		3,549	39
40	ADA Elevator Upgrade	1996	5,548	555	10	555		3,607	40
41	Air Conditioner - Laundry Room	1997	842	84	10	84		400	41
42	Fence & Installation	1997	674	67	10	67		320	42
43	Kitchen A/C & Installation	1997	17,500	2,500	7	2,500		11,872	43
44	Installation of Fire Doors	1997	4,897	196	25	196		897	44
45	Landscape Materials	1998	1,600	160	10	160		667	45
46	Retainers - Int. Design	1998	3,085	308	10	308		1,234	46
47	Interior Design Fees	1998	1,349	135	10	135		517	47
48	Interior Design Fees	1998	3,000	300	10	300		1,149	48
49	Construction Project	1998	11,282	1,128	10	1,128		4,133	49
50	Painting & Staining	1998	13,725	1,373	10	1,373		5,027	50
51	Painting & Staining	1998	13,723	1,372	10	1,372		5,027	51
52	HVAC/Electrical Upgrade	1998	6,482	648	10	648		2,321	52
53	1998 Addition	1998	170,700	6,828	25	6,828		26,732	53
54	Wall & Door Install - Décor	1999	2,850	285	10	285		950	54
55	Architecture, Electrical	1998	10,602	1,060	10	1,060		3,535	55
56	Window Replacement	1998	4,765	476	10	476		1,589	56
57	Energy Study & Admin	1998	1,948	195	10	195		649	57
58	HVAC & Admin	1998	3,325	332	10	332		1,109	58
59	Carpet Installation	1999	125,765	12,577	10	12,577		40,865	59
60	MDC Wallcovering	1998	4,400	440	10	440		1,430	60
61	Add-Ons for Lobby Window	1999	1,800	180	10	180		585	61
62	Install Wood Veener	1999	894	89	10	89		290	62
63	Paint Sprinkler Pipes	1999	120	12	10	12		39	63
64	Air Conditioning	1999	446	18	25	18		55	64
65	Glass repair - bldg décor project	1999	2,659	266	10	266		798	65
66	Remodel 6 resident rooms	1999	720	72	10	72		216	66
67	T20L/F/Roppe & Johnson	1999	170	17	10	17		51	67
68	Installation of Awnings	1999	8,307	831	10	831		2,212	68
69	Couch Wallcovering	1999	61	6	10	6		15	69
70	TOTAL (lines 4 thru 69)		\$ 4,878,383	\$ 178,677		\$ 178,075	\$ (602)	\$ 3,599,458	70

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

Facility Name &amp; ID Number St Matthew Lutheran Home

# 0013896

Report Period Beginning:

07/01/01

Ending:

06/30/02

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	<b>Totals from Page 12A, Carried Forward</b>	\$ 4,878,383	\$ 178,677		\$ 178,075	\$ (602)	\$ 3,599,458		1
2	Installation of Awnings	2000 241	24	10	24		58		2
3	Installation of new windows	2000 35,200	3,520	10	3,520		8,207		3
4	Electric Upgrade	2000 16,253	3,251	5	3,251		6,759		4
5	2000 Addition	2000 49,564	4,956	10	4,956		10,307		5
6	Door to laundry	2000 5,995	600	10	600		1,197		6
7	Furniture & Flooring	2001 341,679	34,168	10	34,168		68,242		7
8	Cable tv system	2001 15,169	1,517	10	1,517		3,030		8
9	Awning Installation	2001 235,000	23,500	10	23,500		46,936		9
10	Exahust Fans Replacement	2001 6,055	606	10	606		1,209		10
11	Air Conditioning Project	2001 88	4	25	4		7		11
12	Air Conditioning project	2001 107,325	4,293	25	4,293		8,574		12
13	Air Conditioning project	2001 253,678	10,147	25	10,147		20,266		13
14	Signs Internally V Shaped	2001 20,570	2,057	10	2,057		4,108		14
15	Air Conditioning project	2001 147,096	5,884	25	5,884		10,752		15
16	Installation of private Cable System	2001 15,170	1,517	10	1,517		2,772		16
17	Seal Coating- St	2001 5,150	206	10	206		376		17
18	Boiler Set Up	2001 214,651	8,586	25	8,586		15,690		18
19	Facility Upgrades	2001 1,509	151	10	151		263		19
20	Facility Upgrades	2001 774	77	10	77		135		20
21	St Matts Air Conditioning	2001 78,348	3,134	25	3,134		5,203		21
22	Windows & Screen Replacement	2001 1,683	168	10	168		266		22
23	Facility Upgrades Cable	2001 5,467	547	10	547		863		23
24	Air Conditioning Project	2001 4,715	189	25	189		282		24
25	Air Conditioning Project	2001 11,400	456	25	456		642		25
26	Garbage Disposers	2001 3,512	350	10	350		438		26
27	Install chilled water cooler	2001 103,301	4,132	25	4,132		4,460		27
28	Fix Door and Wall	2000 3,280	131	25	131		273		28
29	Update Fire Panel	2001 7,051	705	10	705		761		29
30	Valve Project	2001 3,370	134	25	134		134		30
31	Counter Tops	2001 43,338	3,954	10	3,954		3,954		31
32	Windows & Screen	2001 1,683	154	10	154		154		32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>	\$ 6,616,698	\$ 297,795		\$ 297,193	\$ (602)	\$ 3,825,776		34

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

STATE OF ILLINOIS

Facility Name & ID Number St Matthew Lutheran Home

# 0013896

Report Period Beginning:

07/01/01

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06/30/02

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,616,698	\$ 297,795		\$ 297,193	\$ (602)	\$ 3,825,776	1
2	Tree Removal	2001	2,550	147	10	147		147	2
3	Facility Upgrade	2002	37,600	1,622	10	1,535	(87)	1,535	3
4	Facility Upgrade	2002	75,200	597	10	597		597	4
5									5
6									6
7									7
8	FY 89 IDPA Audit - Phone System Amplifiers	1989	491		5			491	8
9	FY 89 IDPA Audit - Garbage Disposer	1989	2,654		5			2,654	9
10	FY 89 IDPA Audit - Ceiling Fans	1989	2,724		7			2,724	10
11	FY 89 IDPA Audit - Toilet Frames	1989	734		5			734	11
12	FY 89 IDPA Audit - Air Conditioner	1989	993		5			993	12
13	Management Assets - Security System	1999	286		10	27	27	N/A	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)		\$ 6,739,930	\$ 300,161		\$ 299,499	\$ (662)	\$ 3,835,651	34

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

Facility Name &amp; ID Number St Matthew Lutheran Home

# 0013896

Report Period Beginning:

07/01/01

Ending:

06/30/02

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 839,991	\$ 72,596	\$ 96,226	\$ 23,630	Various	\$ 317,373	71
72	Current Year Purchases	164,063	14,920	15,918	998	Various	14,920	72
73	Fully Depreciated Assets	503,519				Various	503,519	73
74								74
75	TOTALS	\$ 1,507,573	\$ 87,516	\$ 112,144	\$ 24,628		\$ 835,812	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transp.	1997 Champion Challenger	1997	\$ 54,610	\$ 12,068	\$ 13,507	\$ 1,439	7	\$ 37,048	76
77										77
78										78
79										79
80	TOTALS			\$ 54,610	\$ 12,068	\$ 13,507	\$ 1,439		\$ 37,048	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)	\$ 8,340,817	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 399,745	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 425,150	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 25,405	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,708,511	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1990 Dodge Caravan 1990	\$ 13,609	\$	\$ 13,609	86
87	1988 Dodge Sweptline P.U.plus cover	10,815		10,815	87
88	Management Autos	6,057	1,266	N/A	88
89	1990 Ford Paratransit Van 1990	36,850		36,850	89
90	1997 Ford One	39,963	5,707	29,018	90
91	TOTALS	\$ 107,294	\$ 6,973	\$ 90,292	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?  YES  NO  
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:  
Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2003</u>	\$ _____
13.	<u>/2004</u>	\$ _____
14.	<u>/2005</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34. N/A  
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: \$ 19,689 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			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

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

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

<p>1. HAVE YOU TRAINED AIDES 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. CLASSROOM PORTION:</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 AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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)	N/A			
6	Transportation				
7	Contractual Payments				
8	Nurse Aide 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 aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	N/A
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 aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits	N/A						6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	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 nurse aides, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number St Matthew Lutheran Home

# 0013896

Report Period Beginning: 07/01/01

Ending:

06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/02

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
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):			9
<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	\$	10
<b>B. Long-Term Assets</b>			
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):			23
<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$	24
<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	\$	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
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
<b>Other Current Liabilities(specify):</b>			
36			36
37			37
<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	\$	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	\$	46
47 <b>TOTAL EQUITY</b> (page 18, line 24)	\$	\$	47
<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

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

**Note:**

**Lutheran Social Services of Illinois is unable to provide meaningful comparative balance sheets or statements of changes in equity for individual programs due to the commingling of cash, other**

**assets, and most liabilities in a complex, multi-funtional service agency. Any balance sheet prepared with only those assets, liabilities and fund balances identifiable with specific programs would not balance or pntesent a meaningful picture of that program's financial status.**

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

Facility Name & ID Number St Matthew Lutheran Home

# 0013896

Report Period Beginning: 07/01/01

Ending:

06/30/02

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,295,376	1
2	Discounts and Allowances for all Levels	(454,860)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,840,516	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,020	14
15	Telephone, Television and Radio	408	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 7,428	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	22,497	24
25	Interest and Other Investment Income***	3	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 22,500	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Cookie Sales</u>	921	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 921	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,871,365	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,406,036	31
32	Health Care	3,374,237	32
33	General Administration	1,691,497	33
<b>B. Capital Expense</b>			
34	Ownership	651,810	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	651	35
36	Provider Participation Fee	96,360	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,220,591	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(349,226)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (349,226)	43

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

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

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

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

Facility Name & ID Number **St Matthew Lutheran Home**

# **0013896**

Report Period Beginning: **07/01/01**

Ending:

**06/30/02**

**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	1,834	59,482	30.55	1
2	Assistant Director of Nursing	11,025	134,199	11.24	2
3	Registered Nurses	39,780	915,186	20.46	3
4	Licensed Practical Nurses	42,907	587,385	11.99	4
5	Nurse Aides & Orderlies	64,885	741,161	10.54	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	3,397	44,328	11.28	8
9	Activity Director	2,240	38,848	15.75	9
10	Activity Assistants				10
11	Social Service Workers	5,570	90,935	14.37	11
12	Dietician				12
13	Food Service Supervisor	5,002	73,684	12.51	13
14	Head Cook	5,938	51,421	8.04	14
15	Cook Helpers/Assistants	24,936	200,678	7.49	15
16	Dishwashers				16
17	Maintenance Workers	7,206	117,811	14.42	17
18	Housekeepers	14,415	114,325	7.39	18
19	Laundry	4,973	53,726	9.24	19
20	Administrator				20
21	Assistant Administrator	1,708	60,326	31.29	21
22	Other Administrative	1,448	33,271	20.39	22
23	Office Manager				23
24	Clerical	13,175	162,437	11.37	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	3,766	40,555	9.43	31
32	Other Health Care(specify)				32
33	Other(specify)	3,232	74,814	20.37	33
34	TOTAL (lines 1 - 33)	257,437	3,594,572 *	12.61	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	66,186	1,3	35
36	Medical Director	As Needed	14,700	9,3	36
37	Medical Records Consultant	As Needed	4,080	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	5,759	10,3	39
40	Physical Therapy Consultant	As Needed	250,002	10a,3	40
41	Occupational Therapy Consultant	As Needed	32,880	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	7,401	10a,3	43
44	Activity Consultant	As Needed	9,986	10a,3	44
45	Social Service Consultant				45
46	Other(specify) <u>See Attached</u>	As Needed	35,979	Various	46
47	<u>Legal &amp; Audit Accounting</u>	As Needed	28,545	19,3	47
48	<u>Laundry Services</u>	As Needed	71,506	4,3	48
49	TOTAL (lines 35 - 48)		527,024		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	Nurse Aides			52
53	TOTAL (lines 50 - 52)			53





Facility Name & ID Number St Matthew Lutheran Home# 0013896Report Period Beginning: 07/01/01Ending: 06/30/02**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network \$ 5,442
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,181 Line 10 years
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 96,360  
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 of Public Aid, 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. \$ 1,590
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
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? 0%  
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. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Clifton Gunderson, LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. In Progress, will send when available
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.