FOR BHF USE

LL1

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

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0045807

Facility Name: Meridian Village Care Center

Address: 27 Auerbach Place (Number) | Glen Carbon (City) | 62034 (Zip Code)

County: Madison

Telephone Number: 314-968-9313 **Fax #** 314-968-5590

HFS ID Number:

Date of Initial License for Current Owners: 12/19/2005

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c) 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Paul Ogier **Telephone Number:** 314-968-9313
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2013 to 12/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Paul Ogier
(Title) CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Steve Howell, CPA, Reimbursement Director
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Avenue, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4497 Fax # 314-925-4350

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 3/1/2011

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,577	16,870	5,247	23,694	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,577	16,870	5,247	23,694	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.74%

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

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

I. On what date did you start providing long term care at this location?
Date started 12/19/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/30/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 70 and days of care provided 4,640

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	292,901	13,845	9,161	315,907		315,907	(6)	315,901			1
2	Food Purchase		189,692		189,692		189,692	(2,056)	187,636			2
3	Housekeeping	66,936	11,992	9,459	88,387		88,387		88,387			3
4	Laundry		11,469	67,499	78,968		78,968	6,794	85,762			4
5	Heat and Other Utilities			178,121	178,121		178,121	(20,214)	157,907			5
6	Maintenance	56,236	14,951	72,554	143,741		143,741		143,741			6
7	Other (specify):*											7
8	TOTAL General Services	416,073	241,949	336,794	994,816		994,816	(15,482)	979,334			8
	B. Health Care and Programs											
9	Medical Director			19,000	19,000		19,000		19,000			9
10	Nursing and Medical Records	2,127,711	70,669	114,663	2,313,043		2,313,043		2,313,043			10
10a	Therapy			536,732	536,732		536,732		536,732			10a
11	Activities	103,363	13,718	10,029	127,110		127,110	(1,610)	125,500			11
12	Social Services	34,143	331	10,366	44,840		44,840		44,840			12
13	CNA Training											13
14	Program Transportation	3,640	1,142	800	5,582		5,582	(46)	5,536			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,268,857	85,860	691,590	3,046,307		3,046,307	(1,656)	3,044,651			16
	C. General Administration											
17	Administrative	80,797			80,797		80,797		80,797			17
18	Directors Fees											18
19	Professional Services			482,657	482,657		482,657	(32,069)	450,588			19
20	Dues, Fees, Subscriptions & Promotions			25,586	25,586		25,586		25,586			20
21	Clerical & General Office Expenses	199,299	30,358	129,987	359,644		359,644	(85,746)	273,898			21
22	Employee Benefits & Payroll Taxes			721,116	721,116		721,116		721,116			22
23	Inservice Training & Education											23
24	Travel and Seminar			19,677	19,677		19,677		19,677			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,714	37,714		37,714		37,714			26
27	Other (specify):* Marketing	92,334	14,968	23,862	131,164		131,164	(131,164)				27
28	TOTAL General Administration	372,430	45,326	1,440,599	1,858,355		1,858,355	(248,979)	1,609,376			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,057,360	373,135	2,468,983	5,899,478		5,899,478	(266,117)	5,633,361			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.

Facility Name & ID Number Meridian Village Care Center #0045807 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			336,563	336,563		336,563	(30,322)	306,241			30
31	Amortization of Pre-Op. & Org.			6,841	6,841		6,841		6,841			31
32	Interest			407,537	407,537		407,537		407,537			32
33	Real Estate Taxes			156,174	156,174		156,174		156,174			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			907,115	907,115		907,115	(30,322)	876,793			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		285,635	28,777	314,412		314,412		314,412			39
40	Barber and Beauty Shops			21,559	21,559		21,559	(21,559)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			156,483	156,483		156,483		156,483			42
43	Other (specify):*	2,191,097	655,661	5,267,667	8,114,425		8,114,425	(8,114,425)				43
44	**TOTAL Special Cost Centers**	2,191,097	941,296	5,474,486	8,606,879		8,606,879	(8,135,984)	470,895			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,248,457	1,314,431	8,850,584	15,413,472		15,413,472	(8,432,423)	6,981,049			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 Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6)	1		4
5	Telephone, TV & Radio in Resident Rooms	(20,214)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,254)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(703)	21		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	(422)	21		18
19	Entertainment	(2,056)	2		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	(75,233)	21		24
25	Fund Raising, Advertising and Promotional	(131,164)	27		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	(8,174,096)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,407,148)		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(25,275)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (25,275)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (8,432,423)		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Meridian Village Care Center

ID# 0045807

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty Revenue	$ (21,559)	40	1
2	Miscellaneous Revenue	(6,134)	21	2
3	IL and AL Expenses	(8,114,425)	43	3
4	Transportation Fees	(46)	14	4
5	Senior Fit	(1,610)	11	5
6	Non-care SNF Asset Depreciation	(30,322)	30	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				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**	(8,174,096)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Meridian Village Care Center **#** 0045807 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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	(6)	0	0	0	0	0	0	0	0	0	0	(6)	1
2	Food Purchase	(2,056)	0	0	0	0	0	0	0	0	0	0	(2,056)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	6,794	0	0	0	0	0	0	0	0	0	6,794	4
5	Heat and Other Utilities	(20,214)	0	0	0	0	0	0	0	0	0	0	(20,214)	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	**TOTAL General Services**	(22,276)	6,794	0	0	0	0	0	0	0	0	0	(15,482)	8
	B. Health Care and Programs													
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	(1,610)	0	0	0	0	0	0	0	0	0	0	(1,610)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(46)	0	0	0	0	0	0	0	0	0	0	(46)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,656)	0	0	0	0	0	0	0	0	0	0	(1,656)	16
	C. General Administration													
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	0	(32,069)	0	0	0	0	0	0	0	0	0	(32,069)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(85,746)	0	0	0	0	0	0	0	0	0	0	(85,746)	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(131,164)	0	0	0	0	0	0	0	0	0	0	(131,164)	27
28	**TOTAL General Administration**	(216,910)	(32,069)	0	0	0	0	0	0	0	0	0	(248,979)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(240,842)	(25,275)	0	0	0	0	0	0	0	0	0	(266,117)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meridian Village Care Center # 0045807 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(30,322)	0	0	0	0	0	0	0	0	0	0	(30,322)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(30,322)	0	0	0	0	0	0	0	0	0	0	(30,322)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(21,559)	0	0	0	0	0	0	0	0	0	0	(21,559)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(8,114,425)	0	0	0	0	0	0	0	0	0	0	(8,114,425)	43
44	**TOTAL Special Cost Centers**	(8,135,984)	0	0	0	0	0	0	0	0	0	0	(8,135,984)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,407,148)	(25,275)	0	0	0	0	0	0	0	0	0	(8,432,423)	45

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 PG6-Supp for Listing of BOD				Lutheran Senior Servi	St. Louis, MO	Home Office
				Meridian Village Asso	Glen Carbon, IL	CCRC

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fees	$ 441,995	Lutheran Senior Services	100.00%	$ 409,926	$ (32,069)	1
2	V	4	Laundry	62,413	Lutheran Senior Services	100.00%	69,207	6,794	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			$ 504,408			$ 479,133	$ * (25,275)	14

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	Janice R. Beane	BOD						1
2	Monica Boesdorfer	BOD						2
3	John M. Brant	BOD						3
4	Darrell L. Debowey	BOD						4
5	Mark Gerberding	BOD						5
6	John R. Kotovsky	BOD						6
7	Orlando A. Krueger	BOD						7
8	Victor J. Muchow	BOD						8
9	Sharon L. O'Brien	BOD						9
10	H.A. Olsen	BOD						10
11	Mike Raso	BOD						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 Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Lutheran Senior Services
Street Address: 1150 Hanley Industrial Court
City / State / Zip Code: St. Louis, MO 63144
Phone Number: (314-968-9313
Fax Number: (314-968-5590

	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	Home Office	Direct Costs	162,198,610	24	$ 10,015,880	$ 7,497,646	6,639,069	$ 409,967	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					$ 10,015,880	$ 7,497,646		$ 409,967	25

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Missouri HEFA						$	$			$	1
2	2010 Bonds		X	Campus Expansion	Various	Oct 2010	6,958,280	6,958,280	Feb 2042	Variable	407,537	2
3	2007 C Bonds						2,128,919	2,090,389				3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 9,087,199	$ 9,048,669			$ 407,537	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,087,199	$ 9,048,669			$ 407,537	15

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 156,174	2
3. Under or (over) accrual (line 2 minus line 1).		$ 156,174	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 156,174	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008		8
2009		9
2010		10
2011		11
2012		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meridian Village Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0045807

CONTACT PERSON REGARDING THIS REPORT Paul Ogier

TELEPHONE 314-968-9313 FAX #: 314-968-5590

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-1-15-25-00-000-005.002	Part North 1/2 Northeast	$ 128,761.00	$ 128,761.00
2.	14-1-15-28-00-000-005	Part North 1/2 Northeast	$ 267,914.00	$ 27,413.00
3.	14-1-15-28-00-000-005.001	Part North 1/2 Northeast	$ 102,860.12	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 499,535.12	$ 156,174.00

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,866 B. General Construction Type: Exterior Brick & Siding Frame Wood Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (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).

Meridian Village Association - Independent Living, 55,240 Square Feet, 99 Units
Meridian Village Association III - Assisted Living, 50,790 Square Feet, 66 Units
Meridian Village Association III - Independent Living, 30,716 Square Feet 63 Units

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Senior Living Facility		2003	$ 622,399	1
2					2
3	TOTALS			$ 622,399	3

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	70		2010	2010	$ 6,310,444	$ 189,756	30	$ 189,756	$	$ 600,853	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2006	26,807	1,812	15	1,812		16,051	9
10	Various			2007	14,905	994	15	994		6,459	10
11	PANELS,ACOUSTICAL			2008	3,721	248	15	248		1,364	11
12	CONDENSER-DINING AREA			2008	2,118	141	15	141		777	12
13	CORNER GUARDS			2008	1,257	84	15	84		461	13
14	PAINTING-501-524			2008	950	136	7	136		746	14
15	SOUND SYSTEM			2008	1,763	118	15	118		646	15
16	FLOORING,CARPET-LIVING RM			2009	2,077	297	7	297		1,335	16
17	A/C-HTG-PKG, 15000BTU-COMFORT-KITCHEN			2010	4,282	285	15	285		999	17
18	WIRING/ELECTRICAL-OPTIMUS			2010	3,240	216	15	216		756	18
19	ACCOUSTICAL SOUND TEST			2010	4,000	267	15	267		933	19
20	DOOR W/ KEY PA ENTRY-CC			2010	1,642	109	15	109		383	20
21	A/C&HT, 9,300 BTU			2010	1,176	78	15	78		274	21
22	FLOORING, CARPET			2010	530	76	7	76		265	22
23	DOOR RELEASE, HANDICAP TYPE-VINTAGE GARD			2010	3,052	203	15	203		712	23
24	PAINTING-RM TURNAROUNDS			2010	4,000	571	7	571		2,000	24
25	DOOR RELEASE, HANDICAP-COURTYARD ENTRA			2010	448	64	7	64		224	25
26	A/C, PTAC ISLANDAIRE,9300 BTU			2010	1,176	78	15	78		274	26
27	A/C, PTAC,ISLANDAIR,9300 BTU			2010	1,176	78	15	78		274	27
28	CABINETS, SPA			2010	1,073	72	15	72		250	28
29	ARCHITECTURAL CONSULTANT			2011	227	15	15	15		45	29
30	SIGNS, INTERIOR			2011	134	9	15	9		27	30
31	ARIAL SYSTEM UPGRADE			2011	4,867	324	15	324		919	31
32	DOOR, ACCORDIAN&INSTALLATION			2011	1,007	67	15	67		162	32
33	FLOORING, CARPET-COMMON AREAS,VINATAGE G			2011	16,433	2,348	7	2,348		5,282	33
34	ARCHITECTURAL CONSULTANT			2011	133	9	15	9		27	34
35	SIGNS, INTERIOR			2011	78	5	15	5		16	35
36	A/C, PTAC, 9300 BTU, ISLANDAIR			2012	4,704	314	15	314		627	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOORING, CARPET-#477	2012	$ 631	$ 126	5	$ 126	$	$ 242	37
38	FLOORING, CARPET-RESIDENT RMS	2012	22,314	3,188	7	3,188		4,516	38
39	ELECTRICAL UPGRADES-DATA JACK	2012	874	58	15	58		78	39
40	ARCHITECT CONSULTANT	2013	3,900	97	40	97		97	40
41	FLOORING, CARPET-#98026	2013	951	111	5	111		111	41
42	A/C UNITS- VINTAGE GARDENS	2013	1,165	38	15	38		38	42
43	CAT-5 DATA DROP CC & VINTAGE GARDENS (3)	2013	4,367	194	15	194		194	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	**TOTAL (lines 4 thru 69)**		$ 6,451,621	$ 202,586		$ 202,586	$	$ 648,417	70

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	$ 707,407	$ 100,616	$ 100,616	$	7	$ 323,110	71
72	Current Year Purchases	28,644	3,079	3,079		7	3,079	72
73	Fully Depreciated Assets	82,689					82,689	73
74								74
75	TOTALS	$ 818,740	$ 103,695	$ 103,695	$		$ 408,878	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	Maintenance	2005 Ford E-450	2005	$ 53,735	$	$	$	7	$ 53,735	76
77										77
78										78
79										79
80	TOTALS			$ 53,735	$	$	$		$ 53,735	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)	$ 7,946,495	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 306,281	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 306,281	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,111,030	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	Common Area Renovated - 2006	$ 3,771	$ 251	$ 1,886	86
87	SNF Location (5140 and 5141)	404,484	30,071	44,220	87
88	Independent Living	37,151,280	1,230,725	12,793,086	88
89	Assisted Living	285,862	19,422	149,208	89
90	Assisted Living Dementia	508,167	40,654	179,273	90
91	TOTALS	$ 38,353,564	$ 1,321,123	$ 13,167,673	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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								5
6								6
7	TOTAL				$ **			7

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

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning _____
    Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ _____ Description: _____
    (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					18
19					19
20					20
21	TOTAL		$	$	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.

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	3,398	$ 194,714	$	3,398	$ 194,714	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		2,981	97,432		2,981	97,432	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		1,399	223,137	21,450	1,399	244,587	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-2	# of prescrpts				225,864		225,864	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	7,778	$ 515,283	$ 247,314	7,778	$ 762,597	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.

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (966,354)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	586,666		3
4	Supply Inventory (priced at)	48,260		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	36,554		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Current Assets	31,973		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (262,901)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,754,750		13
14	Buildings, at Historical Cost	42,012,855		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,532,455		16
17	Accumulated Depreciation (book methods)	(14,278,703)		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
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 32,021,357	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 31,758,456	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 173,128	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	295,677		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,541		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				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 480,346	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	669,851		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Related Party- LSS	38,045,478		43
44	Entrance Fees and Resident Deposits	8,067,542		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 46,782,871	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 47,263,217	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (15,504,761)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 31,758,456	$	48

*(See instructions.)

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (15,341,329)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (15,341,329)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(163,432)	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)**	$ (163,432)	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)**	$ (15,504,761)	24 *

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

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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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,429,442	1
2	Discounts and Allowances for all Levels	(1,284,528)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,144,914	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,172,639	6
7	Oxygen	385	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,173,024	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	27,244	13
14	Non-Patient Meals	6	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	245,239	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,999	19
20	Radiology and X-Ray	11,119	20
21	Other Medical Services	44,140	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 335,747	23
	D. Non-Operating Revenue		
24	Contributions	139,522	24
25	Interest and Other Investment Income***	3,254	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 142,776	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	7,777	28
28a	Independent and Assisted Living	8,445,802	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,453,579	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,250,040	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	994,816	31
32	Health Care	3,046,307	32
33	General Administration	1,858,355	33
	B. Capital Expense		
34	Ownership	907,115	34
	C. Ancillary Expense		
35	Special Cost Centers	8,450,396	35
36	Provider Participation Fee	156,483	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,413,472	40
41	**Income before Income Taxes (line 30 minus line 40)****	(163,432)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (163,432)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 312,367	44
45	Private Pay - Net Inpatient Revenue	3,950,812	45
46	Medicare - Net Inpatient Revenue	907,155	46
47	Other-(specify) **Managed Care**	113,962	47
48	Other-(specify) **Benevolent Care**	(139,382)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,144,914	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.**

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,647	1,884	$ 73,630	$ 39.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,409	15,853	440,766	27.80	3
4	Licensed Practical Nurses	20,678	22,501	495,669	22.03	4
5	CNAs & Orderlies	76,684	87,403	1,099,196	12.58	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,881	5,988	107,003	17.87	10
11	Social Service Workers	1,452	1,627	34,143	20.99	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,129	27,129	292,901	10.80	15
16	Dishwashers					16
17	Maintenance Workers	2,739	3,016	56,236	18.65	17
18	Housekeepers	6,481	6,481	66,936	10.33	18
19	Laundry					19
20	Administrator	2,080	2,080	80,797	38.84	20
21	Assistant Administrator					21
22	Other Administrative	12,209	13,457	199,299	14.81	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,339	1,483	18,449	12.44	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing/AL/IL	151,342	166,058	2,283,432	13.75	33
34	TOTAL (lines 1 - 33)	324,070	354,960	$ 5,248,457 *	$ 14.79	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	405	$ 19,684	V1-3, V43-3	35
36	Medical Director	Monthly	19,000	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	73	4,721	V39-3	39
40	Physical Therapy Consultant	77	3,867	V10-a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	196	9,886	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	751	$ 57,158		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Bogner	Care Center Administrator		$ 80,797
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,797

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
McCarthy & Allen	Legal Fees	$ 30,535
Husch Blackwell	Legal Fees	3,536
Lutheran Senior Services	Management Fees	441,995
CliftonLarsonAllen LLP	Accounting	6,591
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 482,657

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,386
Unemployment Compensation Insurance	38,863
FICA Taxes	226,713
Employee Health Insurance	329,306
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	9,509
Pension	2,687
Life Insurance	3,739
Savings and Revenue Sharing Contribution	40,756
Tuition Reimbursement	1,157
TOTAL (agree to Schedule V, line 22, col.8)	$ 721,116

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,691
Advertising: Employee Recruitment	7,942
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 235	5,009
LSN Association	3,174
Other Subs/Publications/Licenses	546
Miscellaneous Dues and Memberships	2,929
Food Sanitation Inspection	296
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,587

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,876
Seminar Expense	12,801
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 19,677

**See instructions.

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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		$		$	$	$	$	$	$	$	$	$

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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 - $3,174**

(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? **19**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,045** Line **39**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **156,483**
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. $ **6**

(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? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
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: **CliftonLarsonAllen**

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