

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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.

I. IDPH License ID Number: 0045807 Facility Name: Meridian Village Care Center Address: 27 Auerbach Place Glen Carbon 62034 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: ☒ VOLUNTARY,NON-PROFIT ☒ Charitable Corp. ☐ Trust IRS Exemption Code 501(c)3 ☐ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Paul Ogier

Telephone Number: 314-968-9313

Email Address:

Facility Name & ID Number Meridian Village Care Center# 0045807 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	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>70</u>	Skilled (SNF)	<u>70</u>	<u>25,620</u>	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	<u>70</u>	TOTALS	<u>70</u>	<u>25,620</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,316</u>	<u>16,123</u>	<u>5,317</u>	<u>23,756</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>2,316</u>	<u>16,123</u>	<u>5,317</u>	<u>23,756</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.72%

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?

YesG. 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 12/19/2005

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 3/30/2005NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 70 and days of care provided 4,945Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	287,579	11,715	6,261	305,555		305,555	(1,304)	304,251			1
2	Food Purchase		158,394		158,394		158,394		158,394			2
3	Housekeeping	10,615	1,785	1,780	14,180		14,180		14,180			3
4	Laundry	275	3,926	68,069	72,270		72,270	(444)	71,826			4
5	Heat and Other Utilities			168,862	168,862		168,862		168,862			5
6	Maintenance	50,112	12,976	61,402	124,490		124,490		124,490			6
7	Other (specify):*											7
8	TOTAL General Services	348,581	188,796	306,374	843,751		843,751	(1,748)	842,003			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	1,951,776	31,966	22,558	2,006,300		2,006,300		2,006,300			10
10a	Therapy			558,588	558,588		558,588		558,588			10a
11	Activities	116,401	15,393	10,927	142,721		142,721	(2,335)	140,386			11
12	Social Services	39,523	278	3,509	43,310		43,310		43,310			12
13	CNA Training											13
14	Program Transportation	3,706	1,024	712	5,442		5,442	(293)	5,149			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,111,406	48,661	623,294	2,783,361		2,783,361	(2,628)	2,780,733			16
	C. General Administration											
17	Administrative	68,998			68,998		68,998		68,998			17
18	Directors Fees											18
19	Professional Services			437,545	437,545		437,545	43,960	481,505			19
20	Dues, Fees, Subscriptions & Promotions			17,775	17,775		17,775		17,775			20
21	Clerical & General Office Expenses	200,892	29,425	104,369	334,686		334,686	(29,258)	305,428			21
22	Employee Benefits & Payroll Taxes			623,720	623,720		623,720		623,720			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,344	15,344		15,344		15,344			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			41,849	41,849		41,849		41,849			26
27	Other (specify):* Marketing	80,186	13,965	16,454	110,605		110,605	(110,605)				27
28	TOTAL General Administration	350,076	43,390	1,257,056	1,650,522		1,650,522	(95,903)	1,554,619			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,810,063	280,847	2,186,724	5,277,634		5,277,634	(100,279)	5,177,355			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			335,835	335,835		335,835	(176,233)	159,602			30
31	Amortization of Pre-Op. & Org.			6,575	6,575		6,575		6,575			31
32	Interest			386,563	386,563		386,563		386,563			32
33	Real Estate Taxes			157,892	157,892		157,892		157,892			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			886,865	886,865		886,865	(176,233)	710,632			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		266,500	35,443	301,943		301,943		301,943			39
40	Barber and Beauty Shops			16,494	16,494		16,494	(16,494)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			180,043	180,043		180,043		180,043			42
43	Other (specify):*	2,055,940	665,776	5,023,763	7,745,479		7,745,479	(7,745,479)				43
44	TOTAL Special Cost Centers	2,055,940	932,276	5,255,743	8,243,959		8,243,959	(7,761,973)	481,986			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,866,003	1,213,123	8,329,332	14,408,458		14,408,458	(8,038,485)	6,369,973			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,304)	1		4
5	Telephone, TV & Radio in Resident Rooms	(17,898)	21		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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(514)	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	(89)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,295)	21		24
25	Fund Raising, Advertising and Promotional	(110,605)	27		25
	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	(7,943,296)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,082,001)		\$	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)	43,516	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 43,516		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (8,038,485)		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

Meridian Village Care Center

Report Period Beginning:

Ending:

ID#0045807

1/1/2012

12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Barber & Beauty Revenue	\$ (16,494)	40	1
2	Miscellaneous Revenue	(2,462)	21	2
3	IL and AL Expenses	(7,745,479)	43	3
4	Transportation Fees	(293)	14	4
5	Senior Fit	(2,335)	11	5
6	Non-care SNF Asset Depreciation	(176,233)	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	(7,943,296)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Meridian Village Care Center

0045807

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,304)	0	0	0	0	0	0	0	0	0	0	(1,304)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(444)	0	0	0	0	0	0	0	0	0	(444)	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	TOTAL General Services	(1,304)	(444)	0	0	0	0	0	0	0	0	0	(1,748)	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	(2,335)	0	0	0	0	0	0	0	0	0	0	(2,335)	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	(293)	0	0	0	0	0	0	0	0	0	0	(293)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,628)	0	0	0	0	0	0	0	0	0	0	(2,628)	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	43,960	0	0	0	0	0	0	0	0	0	43,960	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(29,258)	0	0	0	0	0	0	0	0	0	0	(29,258)	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):*	(110,605)	0	0	0	0	0	0	0	0	0	0	(110,605)	27
28	TOTAL General Administration	(139,863)	43,960	0	0	0	0	0	0	0	0	0	(95,903)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(143,795)	43,516	0	0	0	0	0	0	0	0	0	(100,279)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(176,233)	0	0	0	0	0	0	0	0	0	0	(176,233)	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	(176,233)	0	0	0	0	0	0	0	0	0	0	(176,233)	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	(16,494)	0	0	0	0	0	0	0	0	0	0	(16,494)	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):*	(7,745,479)	0	0	0	0	0	0	0	0	0	0	(7,745,479)	43
44	TOTAL Special Cost Centers	(7,761,973)	0	0	0	0	0	0	0	0	0	0	(7,761,973)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(8,082,001)	43,516	0	0	0	0	0	0	0	0	0	(8,038,485)	45

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 Snior Servic	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.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fees	\$ 417,132	Lutheran Senior Services	100.00%	\$ 461,092	\$ 43,960	1
2	V	4	Laundry	65,133	Lutheran Senior Services	100.00%	64,689	(444)	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			\$ 482,265			\$ 525,781	\$ * 43,516	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:

1/1/2012

Ending:

12/31/2012

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	Richard J. Bagy, Jr.	BOD						1
2	Norma J. Barr	BOD						2
3	Lee H. Bodendieck	BOD						3
4	Rev. Joel T. Christiansen	BOD						4
5	James R. Dankenbring	BOD						5
6	Rev. Dwight E. Dickinson	BOD						6
7	Karl A. Dunajcik	BOD						7
8	Scott M. Hartwig	BOD						8
9	John R. Kotovsky	BOD						9
10	Jan S. Kraemer	BOD						10
11	Kathleen T. Mueller	BOD						11
12	Carla S. Robinson-Rainey	BOD						12
13	William F. Roth	BOD						13
14	Rev. William T. Simmons	BOD						14
15	Roger H. Volk	BOD						15
16	Dr. H. Douglas Walden	BOD						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Lutheran 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	10,973,737	33	\$ 10,973,737	\$ 0	417,132	\$ 417,132	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					\$ 10,973,737	\$		\$ 417,132	25

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							
	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	386,563	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			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			\$	386,563	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.)

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

B. Real Estate Taxes

		Important, 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 2011 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.)		\$	157,892	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	157,892	3	
4. Real Estate Tax accrual used for 2012 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.		\$	157,892	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 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.

2011 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	14-1-15-25-00-000-005.002	Part North 1/2 Northeast	\$ 126,860.00	\$ 126,860.00
2.	14-1-15-28-00-000-005	Part North 1/2 Northeast	\$ 263,957.00	\$ 31,032.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 390,817.00	\$ 157,892.00

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? X YES NO

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

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?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

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

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

☒ 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	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:

1/1/2012

Ending:

12/31/2012

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		\$ 6,310,444	\$ 31,584	30	\$ 31,584	\$	\$ 94,753	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2006		26,807	2,190	15	2,190		14,238	9
10	Various		2007		14,905	994	15	994		5,465	10
11	PANELS,ACOUSTICAL		2008		3,721	248	15	248		1,116	11
12	CONDENSER-DINING AREA		2008		2,118	141	15	141		635	12
13	CORNER GUARDS		2008		1,257	84	15	84		377	13
14	PAINTING-501-524		2008		950	136	7	136		611	14
15	SOUND SYSTEM		2008		1,763	118	15	118		529	15
16	FLOORING,CARPET-LIVING RM		2009		2,077	297	7	297		1,038	16
17	A/C-HTG-PKG, 15000BTU-COMFORT-KITCHEN		2010		4,282	285	15	285		714	17
18	WIRING/ELECTRICAL-OPTIMUS		2010		3,240	216	15	216		540	18
19	ACCOUSTICAL SOUND TEST		2010		4,000	267	15	267		667	19
20	DOOR W/ KEY PA ENTRY-CC		2010		1,642	109	15	109		274	20
21	A/C&HT, 9,300 BTU		2010		1,176	78	15	78		196	21
22	FLOORING, CARPET		2010		530	76	7	76		189	22
23	DOOR RELEASE, HANDICAP TYPE-VINTAGE GARD		2010		3,052	203	15	203		509	23
24	PAINTING-RM TURNAROUNDS		2010		4,000	571	7	571		1,429	24
25	DOOR RELEASE, HANDICAP-COURTYARD ENTRA		2010		448	64	7	64		160	25
26	A/C, PTAC ISLANDAIRE,9300 BTU		2010		1,176	78	15	78		196	26
27	A/C, PTAC,ISLANDAIR,9300 BTU		2010		1,176	78	15	78		196	27
28	CABINETS, SPA		2010		1,073	72	15	72		179	28
29	ARCHITECTURAL CONSULTANT		2011		227	15	15	15		30	29
30	SIGNS, INTERIOR		2011		134	9	15	9		18	30
31	ARIAL SYSTEM UPGRADE		2011		4,867	324	15	324		595	31
32	DOOR, ACCORDIAN&INSTALLATION		2011		1,007	67	15	67		95	32
33	FLOORING, CARPET-COMMON AREAS,VINATAGE G		2011		16,433	2,348	7	2,348		2,934	33
34	ARCHITECTURAL CONSULTANT		2011		133	9	15	9		18	34
35	SIGNS, INTERIOR		2011		78	5	15	5		10	35
36	A/C, PTAC, 9300 BTU, ISLANDAIR		2012		4,704	314	15	314		314	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 FLOORING, CARPET-#477	2012	\$ 631	\$ 116	5	\$ 116	\$	\$ 116	37
38 FLOORING, CARPET-RESIDENT RMS	2012	22,314	1,328	7	1,328		1,328	38
39 ELECTRICAL UPGRADES-DATA JACK	2012	874	19	15	19		19	39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 6,441,238	\$ 42,444		\$ 42,444	\$	\$ 129,488	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$753,844	\$108,208	\$108,208	\$	7	\$288,135	71
72	Current Year Purchases	20,591	1,388	1,388		7	1,388	72
73	Fully Depreciated Assets	15,661				5	15,661	73
74								74
75	TOTALS	\$790,096	\$109,596	\$109,596	\$		\$305,184	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	\$7,562	\$7,562	\$	7	\$53,735	76
77										77
78										78
79										79
80	TOTALS			\$53,735	\$7,562	\$7,562	\$		\$53,735	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$7,907,468	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$159,602	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$159,602	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)	\$488,407	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	\$1,634	86
87	SNF Location (5140 and 5141)	404,484	175,982	330,492	87
88	Independent Living	35,534,523	1,258,008	11,572,319	88
89	Assisted Living	236,520	20,024	129,787	89
90	Assisted Living Dementia	501,636	40,119	138,618	90
91	TOTALS	\$36,680,933	\$1,494,384	\$12,172,850	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$
13.	/2014	\$
14.	/2015	\$

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

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

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
☒ 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_____

Meridian Village does not train C N A's, they are hired already certified.

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	V10A-3	hrs	\$	3,599	\$ 230,490	\$ 2,610	3,599	\$ 233,100	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,770	81,785	75	1,770	81,860	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		3,853	242,229	1,398	3,853	243,627	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				200,186		200,186	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			\$	9,222	\$ 554,504	\$ 204,269	9,222	\$ 758,773	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.

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	\$ (2,379,578)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	495,161		3
4	Supply Inventory (priced at)	38,555		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	60,218		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other Current Assets</u>	22,966		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,762,678)	\$	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	41,575,695		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,390,307		16
17	Accumulated Depreciation (book methods)	(12,661,256)		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)	\$ 33,059,496	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 31,296,818	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 151,483	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	287,116		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,653		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	<u>Refund Clearing Account/Accrued Worke</u>	7,836		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 456,088	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	693,957		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Related Party - LSS</u>	38,021,372		43
44	<u>Entrance Fees and Resident Deposits</u>	7,466,730		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 46,182,059	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 46,638,147	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (15,341,329)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 31,296,818	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,888,687)	1
2	Restatements (describe):		2
3	Net Assets From Meridian Village Association	(5,479,845)	3
4	Net Assets From Meridian Village Association II	(4,879,161)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (15,247,693)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(93,637)	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) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (93,636)	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)	\$ (15,341,329)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meridian Village Care Center# 0045807Report Period Beginning: 1/1/2012Ending: 12/31/2012

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

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

	1		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 6,030,245	1	
2 Discounts and Allowances for all Levels	(990,135)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,040,110	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	1,224,783	6	
7 Oxygen		7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,224,783	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	22,003	13	
14 Non-Patient Meals	1,304	14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs	212,201	17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory	13,299	19	
20 Radiology and X-Ray	6,336	20	
21 Other Medical Services	79,154	21	
22 Laundry	6,760	22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 341,057	23	
D. Non-Operating Revenue			
24 Contributions	109,308	24	
25 Interest and Other Investment Income***		25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 109,308	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 Miscellaneous Revenue	52,644	28	
28a Independent and Assisted Living	7,546,919	28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,599,563	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,314,821	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	843,751	31	
32 Health Care	2,783,361	32	
33 General Administration	1,650,522	33	
B. Capital Expense			
34 Ownership	886,865	34	
C. Ancillary Expense			
35 Special Cost Centers	8,063,916	35	
36 Provider Participation Fee	180,043	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,408,458	40	
41 Income before Income Taxes (line 30 minus line 40)**	(93,637)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (93,637)	43	

	1		2
III. Net Inpatient Revenue detailed by Payer Source	Amount		
44 Medicaid - Net Inpatient Revenue	\$ 437,922	44	
45 Private Pay - Net Inpatient Revenue	3,711,630	45	
46 Medicare - Net Inpatient Revenue	1,004,488	46	
47 Other-(specify) <u>Managed Care</u>	68,022	47	
48 Other-(specify) <u>Benevolent Care</u>	(181,952)	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,040,110	49	

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

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

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	1,984	2,041	\$ 74,938	\$ 36.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,355	15,918	442,327	27.79	3
4	Licensed Practical Nurses	18,402	20,055	420,426	20.96	4
5	CNAs & Orderlies	61,319	83,581	997,302	11.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,420	7,605	120,107	15.79	10
11	Social Service Workers	1,717	1,827	39,523	21.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,174	27,174	287,579	10.58	15
16	Dishwashers					16
17	Maintenance Workers	2,632	2,803	50,112	17.88	17
18	Housekeepers	976	974	10,615	10.90	18
19	Laundry	44	44	275	6.25	19
20	Administrator	1,526	1,817	68,998	37.97	20
21	Assistant Administrator					21
22	Other Administrative	12,718	14,194	200,892	14.15	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	1,318	1,486	16,783	11.29	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing/AL/IL	151,640	166,584	2,274,418	13.65	33
34	TOTAL (lines 1 - 33)	303,225	346,103	\$ 5,004,295 *	\$ 14.46	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	315	\$ 15,668	V1-3, V43-3	35
36	Medical Director	Monthly	12,000	V9-3	36
37	Medical Records Consultant	26	1,560	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	67	4,237	V39-3	39
40	Physical Therapy Consultant	35	1,895	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	58	2,689	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	501	\$ 38,049		49

C. CONTRACT NURSES

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

STATE OF ILLINOIS

0045807

Report Period Beginning:

1/1/2012

Page 21

Ending: 12/31/2012

Facility Name & ID Number

Meridian Village Care Center

XIX. SUPPORT SCHEDULES

A. Administrative Salaries <table> <tr> <th>Name</th> <th>Function</th> <th>Ownership %</th> <th>Amount</th> </tr> <tr> <td>Jacqueline Bogner</td> <td>Care Center Administrator</td> <td></td> <td>\$ 68,998</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td>\$ 68,998</td> </tr> </table>				Name	Function	Ownership %	Amount	Jacqueline Bogner	Care Center Administrator		\$ 68,998																					TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 68,998	D. Employee Benefits and Payroll Taxes <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr><td>Workers' Compensation Insurance</td><td>\$ 68,662</td></tr> <tr><td>Unemployment Compensation Insurance</td><td>15,738</td></tr> <tr><td>FICA Taxes</td><td>207,323</td></tr> <tr><td>Employee Health Insurance</td><td>262,419</td></tr> <tr><td>Employee Meals</td><td> </td></tr> <tr><td>Illinois Municipal Retirement Fund (IMRF)*</td><td> </td></tr> <tr><td>Disability Insurance</td><td>6,118</td></tr> <tr><td>Pension</td><td>2,591</td></tr> <tr><td>Life Insurance</td><td>3,671</td></tr> <tr><td>Savings and Revenue Sharing Contributions</td><td>57,046</td></tr> <tr><td>Tuition Reimbursement</td><td>152</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 22, col.8)</td> <td>\$ 623,720</td> </tr> </table>				Description	Amount	Workers' Compensation Insurance	\$ 68,662	Unemployment Compensation Insurance	15,738	FICA Taxes	207,323	Employee Health Insurance	262,419	Employee Meals		Illinois Municipal Retirement Fund (IMRF)*		Disability Insurance	6,118	Pension	2,591	Life Insurance	3,671	Savings and Revenue Sharing Contributions	57,046	Tuition Reimbursement	152					TOTAL (agree to Schedule V, line 22, col.8)	\$ 623,720	F. Dues, Fees, Subscriptions and Promotions <table> <tr> <th>Description</th> <th>Amount</th> </tr> <tr><td>IDPH License Fee</td><td>\$ </td></tr> <tr><td>Advertising: Employee Recruitment</td><td>7,957</td></tr> <tr><td>Health Care Worker Background Check (Indicate # of checks performed)</td><td> </td></tr> <tr><td>Patient Background Checks</td><td>200 3,885</td></tr> <tr><td>LSN Association Dues</td><td>1,053</td></tr> <tr><td>Food Sanitation Inspection</td><td>180</td></tr> <tr><td>Miscellaneous Dues and Memberships</td><td>2,587</td></tr> <tr><td>Other Subs/Publications/Licenses</td><td>1,136</td></tr> <tr><td>IL Dept of Public Health License</td><td>977</td></tr> <tr><td>Less: Public Relations Expense</td><td>()</td></tr> <tr><td>Non-allowable advertising</td><td>()</td></tr> <tr><td>Yellow page advertising</td><td>()</td></tr> <tr> <td>TOTAL (agree to Sch. V, line 20, col. 8)</td> <td>\$ 17,775</td> </tr> </table>				Description	Amount	IDPH License Fee	\$	Advertising: Employee Recruitment	7,957	Health Care Worker Background Check (Indicate # of checks performed)		Patient Background Checks	200 3,885	LSN Association Dues	1,053	Food Sanitation Inspection	180	Miscellaneous Dues and Memberships	2,587	Other Subs/Publications/Licenses	1,136	IL Dept of Public Health License	977	Less: Public Relations Expense	()	Non-allowable advertising	()	Yellow page advertising	()	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 17,775
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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													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 - \$6,485
- (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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,599 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. \$ 180,043
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. \$ 1,304
- (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?
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 LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.