FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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 1/1/2011 to 12/31/2011 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) Allan B. Larson, CPA, Partner
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Avenue, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4379 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: 1/1/2011 Ending: 12/31/2011

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	56	Skilled (SNF)	70	24,724	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	56	TOTALS	70	24,724	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	2,028	12,612	4,665	19,305	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,028	12,612	4,665	19,305	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.08%

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 4,665

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: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	258,615	10,363	5,461	274,439		274,439	(1,508)	272,931			1
2	Food Purchase		135,358		135,358		135,358		135,358			2
3	Housekeeping	9,597	1,627	1,238	12,462		12,462		12,462			3
4	Laundry	22,103	4,906	69,929	96,938		96,938	5,323	102,261			4
5	Heat and Other Utilities			173,224	173,224		173,224		173,224			5
6	Maintenance	48,775	11,360	56,654	116,789		116,789	(90)	116,699			6
7	Other (specify):*											7
8	TOTAL General Services	339,090	163,614	306,506	809,210		809,210	3,725	812,935			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,790,360	41,018	40,924	1,872,302		1,872,302		1,872,302			10
10a	Therapy			444,584	444,584		444,584		444,584			10a
11	Activities	122,066	13,894	9,990	145,950		145,950	(2,245)	143,705			11
12	Social Services	39,221	321	3,171	42,713		42,713		42,713			12
13	CNA Training											13
14	Program Transportation	3,424	1,096	800	5,320		5,320	(331)	4,989			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,955,071	56,329	511,469	2,522,869		2,522,869	(2,576)	2,520,293			16
	C. General Administration											
17	Administrative	125,906			125,906		125,906		125,906			17
18	Directors Fees											18
19	Professional Services			306,668	306,668		306,668	52,230	358,898			19
20	Dues, Fees, Subscriptions & Promotions			29,287	29,287		29,287		29,287			20
21	Clerical & General Office Expenses	192,985	20,694	70,439	284,118		284,118	(22,399)	261,719			21
22	Employee Benefits & Payroll Taxes			611,427	611,427		611,427		611,427			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,249	16,249		16,249		16,249			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			61,299	61,299		61,299		61,299			26
27	Other (specify):* Marketing	29,570	12,723	18,412	60,705		60,705	(60,705)				27
28	TOTAL General Administration	348,461	33,417	1,113,781	1,495,659		1,495,659	(30,874)	1,464,785			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,642,622	253,360	1,931,756	4,827,738		4,827,738	(29,725)	4,798,013			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: 1/1/2011 Ending: 12/31/2011

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			331,745	331,745		331,745	(188,649)	143,096			30
31	Amortization of Pre-Op. & Org.			2,846	2,846		2,846		2,846			31
32	Interest			384,681	384,681		384,681		384,681			32
33	Real Estate Taxes			88,274	88,274		88,274		88,274			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			807,546	807,546		807,546	(188,649)	618,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		256,041	16,732	272,773		272,773		272,773			39
40	Barber and Beauty Shops			11,602	11,602		11,602	(11,602)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,746	82,746		82,746		82,746			42
43	Other (specify):* IL/AL and Chapla	624,931	5,966	5,629,017	6,259,914		6,259,914	(6,259,914)				43
44	TOTAL Special Cost Centers	624,931	262,007	5,740,097	6,627,035		6,627,035	(6,271,516)	355,519			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,267,553	515,367	8,479,399	12,262,319		12,262,319	(6,489,890)	5,772,429			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: 1/1/2011 Ending: 12/31/2011

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	(1,508)	1		4
5	Telephone, TV & Radio in Resident Rooms	(16,956)	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	(522)	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	(269)	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	(1,830)	21		24
25	Fund Raising, Advertising and Promotional	(60,705)	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	(6,465,653)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,547,443)		$	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)	57,553	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 57,553		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (6,489,890)		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

ID# 0045807

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty Revenue	$ (11,602)	40	1
2	Miscellaneous Revenue	(2,822)	21	2
3	IL,AL and Chaplaincy Expenses	(6,259,914)	43	3
4	Transportation Fees	(331)	14	4
5	Maintenance Service	(90)	6	5
6	Senior Fit	(2,245)	11	6
7	Non-care SNF Asset Depreciation	(188,649)	30	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**	(6,465,653)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Meridian Village Care Center **#** 0045807 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,508)	0	0	0	0	0	0	0	0	0	0	(1,508)	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	5,323	0	0	0	0	0	0	0	0	0	5,323	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(90)	0	0	0	0	0	0	0	0	0	0	(90)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,598)	5,323	0	0	0	0	0	0	0	0	0	3,725	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	(2,245)	0	0	0	0	0	0	0	0	0	0	(2,245)	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	(331)	0	0	0	0	0	0	0	0	0	0	(331)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,576)	0	0	0	0	0	0	0	0	0	0	(2,576)	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	52,230	0	0	0	0	0	0	0	0	0	52,230	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(22,399)	0	0	0	0	0	0	0	0	0	0	(22,399)	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):*	(60,705)	0	0	0	0	0	0	0	0	0	0	(60,705)	27
28	**TOTAL General Administration**	(83,104)	52,230	0	0	0	0	0	0	0	0	0	(30,874)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,278)	57,553	0	0	0	0	0	0	0	0	0	(29,725)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meridian Village Care Center # 0045807 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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	(188,649)	0	0	0	0	0	0	0	0	0	0	(188,649)	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**	(188,649)	0	0	0	0	0	0	0	0	0	0	(188,649)	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	(11,602)	0	0	0	0	0	0	0	0	0	0	(11,602)	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):*	(6,259,914)	0	0	0	0	0	0	0	0	0	0	(6,259,914)	43
44	**TOTAL Special Cost Centers**	(6,271,516)	0	0	0	0	0	0	0	0	0	0	(6,271,516)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,547,443)	57,553	0	0	0	0	0	0	0	0	0	(6,489,890)	45

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 Assoc	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	$ 295,266	Lutheran Senior Services	100.00%	$ 347,496	$ 52,230	1
2	V	4	Laundry	62,141	Lutheran Senior Services	100.00%	67,464	5,323	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			$ 357,407			$ 414,960	$ * 57,553	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: 1/1/2011 Ending: 12/31/2011

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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: 1/1/2011 Ending: 2/31/2011

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	8,530,354	27	$ 8,534,354	$ 0	295,266	$ 295,404	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					$ 8,534,354	$		$ 295,404	25

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	6,938,394	6,938,394	Feb 2042	Variable	384,681	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,938,394	$ 6,938,394			$ 384,681	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,938,394	$ 6,938,394			$ 384,681	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:** 1/1/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 88,274	2
3. Under or (over) accrual (line 2 minus line 1).		$ 88,274	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 88,274	7

Real Estate Tax History:

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

FOR BHF USE ONLY

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

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-1-15-25-00-000-005.002	Part North 1/2 Northeast	$ 323,580.00	$ 88,274.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 323,580.00	$ 88,274.00

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,150 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, 50,246 Square Feet, 66 Units
Meridian Village Association III - Independent Living, 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: 1/1/2011 Ending: 12/31/2011

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	$	$ 63,169	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2006	26,807	2,190	15	2,190		12,048	9
10	Various			2007	14,905	994	15	994		4,471	10
11	PANELS,ACOUSTICAL			2008	3,721	248	15	248		868	11
12	CONDENSER-DINING AREA			2008	2,118	141	15	141		494	12
13	CORNER GUARDS			2008	1,257	84	15	84		293	13
14	PAINTING-501-524			2008	950	136	7	136		475	14
15	SOUND SYSTEM			2008	1,763	118	15	118		411	15
16	FLOORING,CARPET-LIVING RM			2009	2,077	297	7	297		742	16
17	A/C-HTG-PKG, 15000BTU-COMFORT-KITCHEN			2010	4,282	285	15	285		428	17
18	WIRING/ELECTRICAL-OPTIMUS			2010	3,240	216	15	216		324	18
19	ACCOUSTICAL SOUND TEST			2010	4,000	267	15	267		400	19
20	DOOR W/ KEY PA ENTRY-CC			2010	1,642	109	15	109		164	20
21	A/C&HT, 9,300 BTU			2010	1,176	78	15	78		118	21
22	FLOORING, CARPET			2010	530	76	7	76		113	22
23	DOOR RELEASE, HANDICAP TYPE-VINTAGE GARD			2010	3,052	203	15	203		305	23
24	PAINTING-RM TURNAROUNDS			2010	4,000	571	7	571		857	24
25	DOOR RELEASE, HANDICAP-COURTYARD ENTRA			2010	448	64	7	64		96	25
26	A/C, PTAC ISLANDAIRE,9300 BTU			2010	1,176	78	15	78		118	26
27	A/C, PTAC,ISLANDAIR,9300 BTU			2010	1,176	78	15	78		118	27
28	CABINETS, SPA			2010	1,073	72	15	72		107	28
29	ARCHITECTURAL CONSULTANT			2011	227	15	15	15		15	29
30	SIGNS, INTERIOR			2011	134	9	15	9		9	30
31	ARIAL SYSTEM UPGRADE			2011	4,867	270	15	270		270	31
32	DOOR, ACCORDIAN&INSTALLATION			2011	1,007	28	15	28		28	32
33	FLOORING, CARPET-COMMON AREAS,VINATAGE G			2011	16,433	587	7	587		587	33
34	ARCHITECTURAL CONSULTANT			2011	133	9	15	9		9	34
35	SIGNS, INTERIOR			2011	78	5	15	5		5	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,412,715	$ 38,813		$ 38,813	$	$ 87,043	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: 1/1/2011 Ending: 12/31/2011

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	$ 629,915	$ 90,468	$ 90,468	$	7	$ 128,679	71
72	Current Year Purchases	70,194	6,139	6,139		7	6,139	72
73	Fully Depreciated Assets	15,661				5	15,661	73
74								74
75	TOTALS	$ 715,770	$ 96,607	$ 96,607	$		$ 150,479	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	$ 7,676	$ 7,676	$	7	$ 49,896	76
77										77
78										78
79										79
80	TOTALS			$ 53,735	$ 7,676	$ 7,676	$		$ 49,896	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)	$ 7,804,619	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,096	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 143,096	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)	$ 287,418	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	$ 1,383	86
87	SNF Location (5140 and 5141)	457,322	188,398	195,799	87
88	Independent Living	4,867,100	240,148	933,965	88
89	Assisted Living	208,189	22,559	109,763	89
90	Assisted Living Dementia	493,804	39,413	98,499	90
91	TOTALS	$ 6,030,186	$ 490,769	$ 1,339,409	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: 1/1/2011 Ending: 12/31/2011

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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 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: 1/1/2011 Ending: 12/31/2011

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.

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

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: 1/1/2011 Ending: 12/31/2011

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	$	2,620	$ 173,785	$ 3,040	2,620	$ 176,825	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,054	71,370	127	1,054	71,497	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		3,137	192,027	4,235	3,137	196,262	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				199,682		199,682	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			$	6,811	$ 437,182	$ 207,084	6,811	$ 644,266	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.

STATE OF ILLINOIS

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (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	$ 2,406,802	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	546,588		3
4	Supply Inventory (priced at Cost)	39,136		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	40,271		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Miscellaenous Receivable	(89)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,032,708	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	622,399		13
14	Buildings, at Historical Cost	11,817,648		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,394,758		16
17	Accumulated Depreciation (book methods)	(1,626,827)		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): Construction in Progress			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 12,207,978	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 15,240,686	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 164,906	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	258,649		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,798		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	Refund Clearing Account/Accrued Worker	7,021		36
37	Due to LCFS	47,553		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 484,927	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Related Party - LSS	13,627,031		43
44	Entrance Fees and Resident Deposits	6,017,415		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 19,644,446	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 20,129,373	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (4,888,687)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 15,240,686	$	48

*(See instructions.)

Facility Name & ID Number Meridian Village Care Center # 0045807 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,725,147)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,725,147)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(163,536)	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**	(4)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (163,540)	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)**	$ (4,888,687)	24 *

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,606,143	1
2	Discounts and Allowances for all Levels	(480,483)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,125,660	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	910,695	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 910,695	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	11,920	13
14	Non-Patient Meals	1,508	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	203,899	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,331	19
20	Radiology and X-Ray	5,553	20
21	Other Medical Services	60,438	21
22	Laundry	8,240	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 293,889	23
	D. Non-Operating Revenue		
24	Contributions	59,759	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,759	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaenous Revenue	5,488	28
28a	Independent and Assisted Living	6,703,292	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,708,780	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,098,783	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	809,210	31
32	Health Care	2,522,869	32
33	General Administration	1,495,659	33
	B. Capital Expense		
34	Ownership	807,546	34
	C. Ancillary Expense		
35	Special Cost Centers	6,544,289	35
36	Provider Participation Fee	82,746	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,262,319	40
41	**Income before Income Taxes (line 30 minus line 40)****	(163,536)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (163,536)	43

* **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.**

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	1,984	2,160	$ 75,586	$ 34.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,889	19,077	469,642	24.62	3
4	Licensed Practical Nurses	17,761	18,434	383,106	20.78	4
5	CNAs & Orderlies	54,234	75,193	837,706	11.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,570	8,676	122,066	14.07	10
11	Social Service Workers	2,241	2,358	42,645	18.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,680	26,680	258,615	9.69	15
16	Dishwashers					16
17	Maintenance Workers	2,861	3,089	48,775	15.79	17
18	Housekeepers	957	1,037	9,597	9.25	18
19	Laundry	1,940	2,142	22,103	10.32	19
20	Administrator	1,034	1,131	47,721	42.19	20
21	Assistant Administrator	2,160	2,160	78,185	36.20	21
22	Other Administrative	13,698	20,539	192,985	9.40	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	2,241	2,395	24,320	10.15	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing/AL/IL	94,460	100,782	654,501	6.49	33
34	TOTAL (lines 1 - 33)	248,710	285,853	$ 3,267,553 *	$ 11.43	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	314	$ 15,612	V1-3, V43-3	35
36	Medical Director	Monthly	12,000	V9-3	36
37	Medical Records Consultant	25	1,500	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	146	9,506	V39-3	39
40	Physical Therapy Consultant	59	3,118	V10-a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	921	V11-3	44
45	Social Service Consultant	28	2,611	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	586	$ 45,268		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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Collen Bottens	Executive DIrector	0	$ 16,403
Deanna Krankel	Executive DIrector	0	31,318
Jacqueline Bogner	Care Center Administrator	0	78,185
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 125,906

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
CliftonLarsonAllen LLP	Accounting	$ 7,626
Lutheran Senior Services	Management Fees	295,266
Edward T McCarthy & Associates	Legal Fees	1,795
The Stolar Partnership	Legal Fees	1,169
McCarthy & Allen	Legal Fees	812
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 306,668

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,290
Unemployment Compensation Insurance	19,237
FICA Taxes	193,282
Employee Health Insurance	252,071
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	5,604
Pension	4,546
Life Insurance	3,381
Savings and Revenue Sharing Contributions	48,629
Tuition Reimbursement	387
TOTAL (agree to Schedule V, line 22, col.8)	$ 611,427

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,923
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 200	4,209
LSN Association Dues	3,780
Food Sanitation Inspection	313
Miscellaneous Dues and Memberships	102
Other Subs/Publications/Licenses	1,867
IL Dept of Public Health License	2,093
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,287

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,970
Seminar Expense	12,279
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,249

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 - $7,571**

(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. $ **12,355** 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. $ **82,746**
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. $ **1,508**

(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.