FOR BHF USE

LL1

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 (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
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501 (c) 3

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 01/01/2014 to 12/31/2014 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) Amanda Tinney, CPA, Principal
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Avenue, Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4389 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: 01/01/2014 Ending: 12/31/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/1/2011

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,549	14,134	5,483	22,166	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,549	14,134	5,483	22,166	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.76%

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 4,354

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number Meridian Village Care Center # 0045807 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	300,377	10,839	6,783	317,999		317,999	(34)	317,965			1
2	Food Purchase		170,691		170,691		170,691	(1,817)	168,874			2
3	Housekeeping	80,415	12,317	12,772	105,504		105,504		105,504			3
4	Laundry		9,673	70,659	80,332		80,332	22,182	102,514			4
5	Heat and Other Utilities			182,851	182,851		182,851	(22,701)	160,150			5
6	Maintenance	68,422	22,818	79,119	170,359		170,359		170,359			6
7	Other (specify):*											7
8	**TOTAL General Services**	449,214	226,338	352,184	1,027,736		1,027,736	(2,370)	1,025,366			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	2,134,907	90,426	88,658	2,313,991		2,313,991		2,313,991			10
10a	Therapy			617,230	617,230		617,230		617,230			10a
11	Activities	70,173	14,218	6,898	91,289		91,289	(2,036)	89,253			11
12	Social Services	42,465	449	4,113	47,027		47,027		47,027			12
13	CNA Training											13
14	Program Transportation	5,160	1,410	871	7,441		7,441	(1,072)	6,369			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,252,705	106,503	737,270	3,096,478		3,096,478	(3,108)	3,093,370			16
	C. General Administration											
17	Administrative	72,262			72,262		72,262		72,262			17
18	Directors Fees											18
19	Professional Services			464,004	464,004		464,004	3,683	467,687			19
20	Dues, Fees, Subscriptions & Promotions			26,356	26,356		26,356		26,356			20
21	Clerical & General Office Expenses	257,514	29,199	301,088	587,801		587,801	(63,094)	524,707			21
22	Employee Benefits & Payroll Taxes			659,102	659,102		659,102		659,102			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,633	15,633		15,633		15,633			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			42,814	42,814		42,814		42,814			26
27	Other (specify):* MARKETING	81,566	17,001	23,158	121,725		121,725	(121,725)				27
28	**TOTAL General Administration**	411,342	46,200	1,532,155	1,989,697		1,989,697	(181,136)	1,808,561			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,113,261	379,041	2,621,609	6,113,911		6,113,911	(186,614)	5,927,297			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:** 01/01/2014 **Ending:** 12/31/2014

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			341,340	341,340		341,340	(30,444)	310,896			30
31	Amortization of Pre-Op. & Org.			441	441		441		441			31
32	Interest			405,169	405,169		405,169		405,169			32
33	Real Estate Taxes			147,851	147,851		147,851		147,851			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			894,801	894,801		894,801	(30,444)	864,357			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		253,287	23,570	276,857		276,857		276,857			39
40	Barber and Beauty Shops			39,434	39,434		39,434	(28,072)	11,362			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			148,671	148,671		148,671		148,671			42
43	Other (specify):* AL/IL	2,309,658	746,880	5,061,982	8,118,520		8,118,520	(8,118,520)				43
44	**TOTAL Special Cost Centers**	2,309,658	1,000,167	5,273,657	8,583,482		8,583,482	(8,146,592)	436,890			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,422,919	1,379,208	8,790,067	15,592,194		15,592,194	(8,363,650)	7,228,544			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: 01/01/2014 Ending: 12/31/2014

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	(34)	1		4
5	Telephone, TV & Radio in Resident Rooms	(22,701)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,185)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(693)	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	(1,076)	21		18
19	Entertainment	(1,817)	2		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,231)	21		24
25	Fund Raising, Advertising and Promotional	(121,725)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,193,053)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,389,515)		$	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)	3,683	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 3,683		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (8,385,832)		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: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty Revenue	$ (28,072)	40	1
2	Miscellaneous Revenue	(12,909)	21	2
3	IL and AL Expenses	(8,118,520)	43	3
4	Transportation Fees	(1,072)	14	4
5	Senior Fit	(2,036)	11	5
6	Non-care SNF Asset Depreciation	(30,444)	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,193,053)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Meridian Village Care Center **#** 0045807 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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	(34)	0	0	0	0	0	0	0	0	0	0	(34)	1
2	Food Purchase	(1,817)	0	0	0	0	0	0	0	0	0	0	(1,817)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	22,182	0	0	0	0	0	0	0	0	0	22,182	4
5	Heat and Other Utilities	(22,701)	0	0	0	0	0	0	0	0	0	0	(22,701)	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**	(24,552)	22,182	0	0	0	0	0	0	0	0	0	(2,370)	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	(2,036)	0	0	0	0	0	0	0	0	0	0	(2,036)	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	(1,072)	0	0	0	0	0	0	0	0	0	0	(1,072)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,108)	0	0	0	0	0	0	0	0	0	0	(3,108)	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	3,683	0	0	0	0	0	0	0	0	0	3,683	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(63,094)	0	0	0	0	0	0	0	0	0	0	(63,094)	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):*	(121,725)	0	0	0	0	0	0	0	0	0	0	(121,725)	27
28	**TOTAL General Administration**	(184,819)	3,683	0	0	0	0	0	0	0	0	0	(181,136)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(212,479)	25,865	0	0	0	0	0	0	0	0	0	(186,614)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meridian Village Care Center **#** 0045807 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(30,444)	0	0	0	0	0	0	0	0	0	0	(30,444)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(30,444)	0	0	0	0	0	0	0	0	0	0	(30,444)	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	(28,072)	0	0	0	0	0	0	0	0	0	0	(28,072)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(8,118,520)	0	0	0	0	0	0	0	0	0	0	(8,118,520)	43
44	**TOTAL Special Cost Centers**	(8,146,592)	0	0	0	0	0	0	0	0	0	0	(8,146,592)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,389,515)	25,865	0	0	0	0	0	0	0	0	0	(8,363,650)	45

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See PG6-Supp for Listing of BOD				Lutheran Senior Servi	St. Louis, MO	Home Office
				Meridian Village Asso	Glen Carbon, IL	CCRC

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fees	$ 446,675	Lutheran Senior Services	100.00%	$ 450,358	$ 3,683	1
2	V	4	Laundry	61,904	Lutheran Senior Services	100.00%	84,086	22,182	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			$ 508,579			$ 534,444	$ * 25,865	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: 01/01/2014 Ending: 12/31/2014

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 BAGY	BOD						1
2	NORMA BARR	BOD						2
3	LEE BODENDIECK	BOD						3
4	REV. JOEL CHRISTIANSEN	BOD						4
5	JAMES DANKENBRING	BOD						5
6	DIANE DROLLINGER	BOD						6
7	KARL DUNAJCIK	BOD						7
8	SCOTT HARTWIG	BOD						8
9	JOHN KOTOVSKY	BOD						9
10	JOHN KOMLOS	BOD						10
11	WILLIAM LUCAS	BOD						11
12	KATHLEEN MUELLER	BOD						12
13	CARLA ROBINSON-RAINEY	BOD						13
14	WILLIAM ROTH	BOD						14
15	REV. WILLIAM SIMMONS	BOD						15
16	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: 01/01/2014 Ending: 12/31/2014

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: 01/01/2014 Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	HOME OFFICE	DIRECT COSTS	162,046,477	24	$ 10,875,988	$ 7,976,988	6,710,102	$ 450,358	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					$ 10,875,988	$ 7,976,988		$ 450,358	25

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Missouri HEFA						$	$			$	1
2	2010 Bonds		X	Campus Expansion	Various	Oct 2010	6,958,280	6,837,889	Feb 2042	Variable	405,169	2
3	2007 C Bonds						2,128,919	2,054,221				3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 9,087,199	$ 8,892,110			$ 405,169	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	$ 8,892,110			$ 405,169	15

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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.)		$ 147,851	2
3. Under or (over) accrual (line 2 minus line 1).		$ 147,851	3
4. Real Estate Tax accrual used for 2014 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.		$ 147,851	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2009		8
2010		9
2011		10
2012		11
2013		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-1-15-21-00-000-004.010	S PT SE	$ 1,213.52	$
2.	14-1-15-28-00-000-005.002	Part North 1/2 Northeast	$ 268,648.72	$
3.	14-1-15-28-00-000-005.001	PT N 1/2 NE	$ 81,050.56	$ 18,153.76
4.	14-1-15-28-00-000-005	PT N 1/2 NE	$ 129,697.24	$ 129,697.24
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 480,610.04	$ 147,851.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X _____ 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 01/01/2014 Ending: 12/31/2014

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,866 B. General Construction Type: Exterior BRICK & SIDING Frame WOOD Number of Stories 1

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	70		2010	2010	$ 6,310,444	$ 189,505		$ 189,505	$	$ 789,603	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2006	26,806	1,434		1,434		17,485	9
10	Various			2007	14,905	994		994		7,452	10
11	PANELS,ACOUSTICAL			2008	3,721	248		248		1,612	11
12	CONDENSER-DINING AREA			2008	2,118	141		141		918	12
13	CORNER GUARDS			2008	1,257	84		84		545	13
14	PAINTING-501-524			2008	950	136		136		882	14
15	SOUND SYSTEM			2008	1,763	118		118		764	15
16	FLOORING,CARPET-LIVING RM			2009	2,077	297		297		1,632	16
17	A/C-HTG-PKG, 15000BTU-COMFORT-KITCHEN			2010	4,282	285		285		1,285	17
18	WIRING/ELECTRICAL-OPTIMUS			2010	3,240	216		216		972	18
19	ACCOUSTICAL SOUND TEST			2010	4,000	267		267		1,200	19
20	DOOR W/ KEY PA ENTRY-CC			2010	1,642	109		109		493	20
21	A/C&HT, 9,300 BTU			2010	1,176	78		78		353	21
22	FLOORING, CARPET			2010	530	76		76		340	22
23	DOOR RELEASE, HANDICAP TYPE-VINTAGE GARD			2010	3,052	203		203		916	23
24	PAINTING-RM TURNAROUNDS			2010	4,000	571		571		2,571	24
25	DOOR RELEASE, HANDICAP-COURTYARD ENTRA			2010	448	64		64		288	25
26	A/C, PTAC ISLANDAIRE,9300 BTU			2010	1,176	78		78		352	26
27	A/C, PTAC,ISLANDAIR,9300 BTU			2010	1,176	78		78		352	27
28	CABINETS, SPA			2010	1,073	72		72		322	28
29	ARCHITECTURAL CONSULTANT			2011	227	15		15		60	29
30	SIGNS, INTERIOR			2011	134	9		9		36	30
31	ARIAL SYSTEM UPGRADE			2011	4,867	324		324		1,243	31
32	DOOR, ACCORDIAN&INSTALLATION			2011	1,007	67		67		229	32
33	FLOORING, CARPET-COMMON AREAS,VINATAGE G			2011	16,433	2,348		2,348		7,630	33
34	ARCHITECTURAL CONSULTANT			2011	133	9		9		36	34
35	SIGNS, INTERIOR			2011	78	5		5		21	35
36	A/C, PTAC, 9300 BTU, ISLANDAIR			2012	4,704	314		314		941	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: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOORING, CARPET-RESIDENT RMS	2012	22,314	3,188	7	3,188		7,704	37
38	ELECTRICAL UPGRADES-DATA JACK	2012	874	58	15	58		136	38
39	ARCHITECT CONSULTANT	2013	3,900	98	40	98		195	39
40	FLOORING, CARPET-#98026	2013	951	190	5	190		301	40
41	A/C UNITS- VINTAGE GARDENS	2013	1,165	78	15	78		116	41
42	CAT-5 DATA DROP CC & VINTAGE GARDENS (3)	2013	4,367	291	15	291		485	42
43	FLOORING - VINYL - ROOM #524	2014	249	33	5	33		33	43
44	FLOORING-CARPET ROOM #512	2014	1,250	83	5	83		83	44
45	FLOORING-CARPET ROOM #628	2014	834	42	5	42		42	45
46	FLOORING-VINYL ROOM #512	2014	1,226	41	5	41		41	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)		$ 6,454,546	$ 202,247		$ 202,247	$	$ 849,669	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: 01/01/2014 Ending: 12/31/2014

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	$ 724,395	$ 103,870	$ 103,870	$	VARIOUS	$ 419,291	71
72	Current Year Purchases	49,701	4,779	4,779		VARIOUS	4,779	72
73	Fully Depreciated Assets	95,892				VARIOUS	95,892	73
74								74
75	TOTALS	$ 869,988	$ 108,649	$ 108,649	$		$ 519,962	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	2005 Ford E-450	2005	$ 53,735	$	$	$	7	$ 53,735	76
77										77
78										78
79										79
80	TOTALS			$ 53,735	$	$	$		$ 53,735	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,000,668	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 310,896	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 310,896	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,423,366	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	$ 2,137	86
87	SNF Location (5140 and 5141)	405,009	30,193	72,732	87
88	Independent Living	37,750,395	1,294,123	14,065,607	88
89	Assisted Living	371,928	29,841	179,372	89
90	Assisted Living Dementia	515,229	42,236	221,507	90
91	TOTALS	$ 39,046,332	$ 1,396,644	$ 14,541,355	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: 01/01/2014 Ending: 12/31/2014

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: 01/01/2014 Ending: 12/31/2014

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

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

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

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

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

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

MERIDIAN VILLAGE DOES NOT TRAIN CNA'S, THEY ARE HIRED ALREADY CERTIFIED.

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: 01/01/2014 Ending: 12/31/2014

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	3,545	$ 243,034	$	3,545	$ 243,034	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,493	101,446		1,493	101,446	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		3,587	242,123	30,627	3,587	272,750	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				218,669		218,669	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			$	8,625	$ 586,603	$ 249,296	8,625	$ 835,899	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: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014 (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	$ (608,675)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (68,000))	940,036		3
4	Supply Inventory (priced at)	46,666		4
5	Short-Term Investments			5
6	Prepaid Insurance	37,251		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): OTHER ASSETS	25,886		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 441,164	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,541,449		13
14	Buildings, at Historical Cost	42,662,211		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,843,340		16
17	Accumulated Depreciation (book methods)	(15,964,722)		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)**	$ 31,082,278	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 31,523,442	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 165,448	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	330,057		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,046		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	ACCRUED WORKERS COMPENSATIC	335		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 507,886	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	757,735		39
40	Mortgage Payable			40
41	Bonds Payable	37,287,743		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	ENTRANCE FEES	8,120,195		43
44	DEPOSITS	249,214		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 46,414,887	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 46,922,773	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (15,399,331)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 31,523,442	$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (15,504,761)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (15,504,761)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	105,430	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 105,430	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)**	$ (15,399,331)	24 *

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,369,799	1
2	Discounts and Allowances for all Levels	(1,395,240)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,974,559	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,332,259	6
7	Oxygen	4,135	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,336,394	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	28,072	13
14	Non-Patient Meals	34	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	235,378	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,407	19
20	Radiology and X-Ray	8,061	20
21	Other Medical Services	27,482	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 317,434	23
	D. Non-Operating Revenue		
24	Contributions	101,598	24
25	Interest and Other Investment Income***	11,185	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 112,783	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER REVENUE	16,017	28
28a	AL/IL REVENUE	8,940,437	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,956,454	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,697,624	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,027,736	31
32	Health Care	3,096,478	32
33	General Administration	1,989,697	33
	B. Capital Expense		
34	Ownership	894,801	34
	C. Ancillary Expense		
35	Special Cost Centers	8,434,811	35
36	Provider Participation Fee	148,671	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,592,194	40
41	**Income before Income Taxes (line 30 minus line 40)****	105,430	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 105,430	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 534,266	44
45	Private Pay - Net Inpatient Revenue	3,536,208	45
46	Medicare - Net Inpatient Revenue	873,401	46
47	Other-(specify) Managed Care	223,455	47
48	Other-(specify) Benevolent Care	(192,771)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,974,559	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,895	6,735	$ 77,333	$ 11.48	1
2	Assistant Director of Nursing	-	-	-		2
3	Registered Nurses	16,249	12,834	526,611	41.03	3
4	Licensed Practical Nurses	19,257	21,078	468,583	22.23	4
5	CNAs & Orderlies	71,992	82,861	1,046,401	12.63	5
6	CNA Trainees	-	-	-		6
7	Licensed Therapist	-	-	-		7
8	Rehab/Therapy Aides	-	-	-		8
9	Activity Director	-	-	-		9
10	Activity Assistants	6,119	6,301	132,214	20.98	10
11	Social Service Workers	2,063	2,181	42,465	19.47	11
12	Dietician	-	-	-		12
13	Food Service Supervisor	-	-	-		13
14	Head Cook	-	-	-		14
15	Cook Helpers/Assistants	26,420	26,420	300,377	11.37	15
16	Dishwashers	-	-	-		16
17	Maintenance Workers	3,213	3,438	68,422	19.90	17
18	Housekeepers	7,542	7,542	80,415	10.66	18
19	Laundry	-	-	-		19
20	Administrator	-	-	-		20
21	Assistant Administrator	-	-	72,262		21
22	Other Administrative	14,619	16,025	185,252	11.56	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	1,168	1,227	15,723	12.82	31
32	Other Health Care(specify)	2,610	2,801	81,566	29.12	32
33	Other(specify)	96,394	108,241	2,325,296	21.48	33
34	TOTAL (lines 1 - 33)	269,539	297,682	$ 5,422,919 *	$ 18.22	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	326	$ 16,163	V1-3, V43-3	35
36	Medical Director	Monthly	19,500	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	207	4,725	V39-3	39
40	Physical Therapy Consultant	38	2,079	V10a-3	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	3,523	V12-3	45
46	Other(specify) MDS INTERIM	472	47,901	V10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,101	$ 93,891		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Bogner	Care Center Administrator		$ 58,522
Barbara Varwig	Care Center Administrator		13,740
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,262

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
BROWN & JAMES, P.C.	LEGAL FEES	$ 7,566
HEPLER BROOM LLC	LEGAL FEES	433
HUSCH BLACKWELL	LEGAL FEES	1,380
POLSINELLI PC	LEGAL FEES	2,172
CLIFTONLARSONALLEN LLP	ACCOUNTING FEES	5,778
LUTHERAN SENIOR SERVICES	MANAGEMENT FEES	446,675
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 464,004

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,655
Unemployment Compensation Insurance	43,779
FICA Taxes	228,492
Employee Health Insurance	249,413
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	2,709
DISABILITY INSURANCE	9,219
LIFE INSURANCE	3,771
SAVINGS AND REVENUE SHARING	44,755
TUITION REIMBURSEMENT	2,981
DENTAL INSURANCE	16,328
TOTAL (agree to Schedule V, line 22, col.8)	$ 659,102

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	1,284
Health Care Worker Background Check	
(Indicate # of checks performed ____)	
Patient Background Checks 164	3,486
LSN Association	2,509
Other Subs/Publications/Licenses	16,279
Miscellaneous Dues and Memberships	2,798
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,356

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,494
Seminar Expense	7,139
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,633

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN - $5,901**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **19**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ 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. **N/A**

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **148,671**
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. $ **34**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(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 out of Schedule V? **YES**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.