FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 12/19/05

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: Kevin Wellen **Telephone Number:** 314-925-4446
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 1/01/2016 to 12/31/2016 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) Chief Financial Officer

Paid Preparer
(Signed) (Date)
(Print Name and Title) Kevin Wellen, CPA, Director
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave. Suite 1800, St. Louis, MO 63101
(Telephone) 314-925-4446 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: 1/01/2016 Ending: 12/31/2016

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 N/A

	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	25,620	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	25,620	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	2,093	14,491	6,904	23,488	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,093	14,491	6,904	23,488	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.68%

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)
None

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 [X] NO [ ]

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 4,388

Medicare Intermediary

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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	240,744	6,396	21,652	268,792		268,792	(110)	268,682			1
2	Food Purchase		172,213		172,213		172,213	(1,653)	170,560			2
3	Housekeeping	88,468	13,401	17,180	119,049		119,049		119,049			3
4	Laundry		11,393	63,400	74,793		74,793	(5,087)	69,706			4
5	Heat and Other Utilities			142,756	142,756		142,756	(24,025)	118,731			5
6	Maintenance	80,949	17,814	84,343	183,106		183,106	(1,227)	181,879			6
7	Other (specify):*											7
8	TOTAL General Services	410,161	221,217	329,331	960,709		960,709	(32,102)	928,607			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,995,378	46,180	36,511	2,078,069	(8,527)	2,069,542		2,069,542			10
10a	Therapy			654,383	654,383		654,383		654,383			10a
11	Activities	127,799	15,500	26,228	169,527	(124)	169,403	(1,395)	168,008			11
12	Social Services	52,238	88	3,787	56,113		56,113		56,113			12
13	CNA Training											13
14	Program Transportation	8,129	1,186	1,065	10,380		10,380	(966)	9,414			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,183,544	62,954	745,974	2,992,472	(8,651)	2,983,821	(2,361)	2,981,460			16
	C. General Administration											
17	Administrative	90,848			90,848		90,848		90,848			17
18	Directors Fees											18
19	Professional Services			624,235	624,235		624,235	2,138	626,373			19
20	Dues, Fees, Subscriptions & Promotions			25,974	25,974	5,454	31,428		31,428			20
21	Clerical & General Office Expenses	527,179	39,704	391,859	958,742	(6,475)	952,267	(412,370)	539,897			21
22	Employee Benefits & Payroll Taxes			718,634	718,634		718,634		718,634			22
23	Inservice Training & Education											23
24	Travel and Seminar			15,793	15,793		15,793		15,793			24
25	Other Admin. Staff Transportation			50,408	50,408		50,408		50,408			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):* Marketing	88,317	17,756	80,837	186,910		186,910	(186,910)				27
28	TOTAL General Administration	706,344	57,460	1,907,740	2,671,544	(1,021)	2,670,523	(597,142)	2,073,381			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,300,049	341,631	2,983,045	6,624,725	(9,672)	6,615,053	(631,605)	5,983,448			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: 1/01/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			402,321	402,321		402,321	(11,510)	390,811			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			358,990	358,990		358,990	(52,451)	306,539			32
33	Real Estate Taxes			163,184	163,184		163,184		163,184			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					9,672	9,672		9,672			35
36	Other (specify):*											36
37	**TOTAL Ownership**			924,495	924,495	9,672	934,167	(63,961)	870,206			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		428,349	72,285	500,634		500,634		500,634			39
40	Barber and Beauty Shops			37,677	37,677		37,677	(37,677)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			146,913	146,913		146,913		146,913			42
43	Other (specify):* IL and AL	2,512,214	749,022	6,116,229	9,377,465		9,377,465	(9,377,465)				43
44	**TOTAL Special Cost Centers**	2,512,214	1,177,371	6,373,104	10,062,689		10,062,689	(9,415,142)	647,547			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,812,263	1,519,002	10,280,644	17,611,909		17,611,909	(10,110,708)	7,501,201			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: 1/01/2016 Ending: 12/31/2016

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	(110)	1		4
5	Telephone, TV & Radio in Resident Rooms	(24,025)	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	(33,733)	30		9
10	Interest and Other Investment Income	(4,099)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(42,516)	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	(586)	21		18
19	Entertainment	(1,653)	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	(367,412)	21		24
25	Fund Raising, Advertising and Promotional	(186,910)	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 SEE PG5A	(9,423,007)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,084,051)		$	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)	(26,657)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (26,657)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (10,110,708)		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: 1/01/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Beauty Shop Income	$ (37,677)	40	1
2	Transportation Income	(966)	14	2
3	Miscellaneous Income	(1,856)	21	3
4	Interest on Past Due Accounts	(2,421)	32	4
5	Maintenance Services Income	(1,227)	6	5
6				6
7				7
8	IL and AL Expenses	(9,377,465)	43	8
9	Senior Fit	(1,395)	11	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**	(9,423,007)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Meridian Village Care Center # 0045807 **Report Period Beginning:** 1/01/2016 **Ending:** 12/31/2016

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	(110)	0	0	0	0	0	0	0	0	0	0	(110)	1
2	Food Purchase	(1,653)	0	0	0	0	0	0	0	0	0	0	(1,653)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(5,087)	0	0	0	0	0	0	0	0	0	(5,087)	4
5	Heat and Other Utilities	(24,025)	0	0	0	0	0	0	0	0	0	0	(24,025)	5
6	Maintenance	(1,227)	0	0	0	0	0	0	0	0	0	0	(1,227)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(27,015)	(5,087)	0	0	0	0	0	0	0	0	0	(32,102)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,395)	0	0	0	0	0	0	0	0	0	0	(1,395)	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	(966)	0	0	0	0	0	0	0	0	0	0	(966)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,361)	0	0	0	0	0	0	0	0	0	0	(2,361)	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	2,138	0	0	0	0	0	0	0	0	0	2,138	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(412,370)	0	0	0	0	0	0	0	0	0	0	(412,370)	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):*	(186,910)	0	0	0	0	0	0	0	0	0	0	(186,910)	27
28	**TOTAL General Administration**	(599,280)	2,138	0	0	0	0	0	0	0	0	0	(597,142)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(628,656)	(2,949)	0	0	0	0	0	0	0	0	0	(631,605)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meridian Village Care Center # 0045807 **Report Period Beginning:** 1/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(33,733)	22,223	0	0	0	0	0	0	0	0	0	(11,510)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,520)	(45,931)	0	0	0	0	0	0	0	0	0	(52,451)	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**	(40,253)	(23,708)	0	0	0	0	0	0	0	0	0	(63,961)	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	(37,677)	0	0	0	0	0	0	0	0	0	0	(37,677)	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):*	(9,377,465)	0	0	0	0	0	0	0	0	0	0	(9,377,465)	43
44	**TOTAL Special Cost Centers**	(9,415,142)	0	0	0	0	0	0	0	0	0	0	(9,415,142)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,084,051)	(26,657)	0	0	0	0	0	0	0	0	0	(10,110,708)	45

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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 Board Listing at PG6-Supp		Lutheran Convalescent Home	Webster, MO	Lutheran Senior Servi	St. Louis, MO	Home Office
		Mason Pointe Care Center	Chesterfield, MO			
		Breeze Park	St. Charles, MO			
		Heisinger Lutheran Home	Jefferson City, MO			
		Lenori Woods	Columbia, MO			
		Concordia Village Care Center	Springfield, IL			
		Meramec Bluffs	St. Louis, MO			

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 Fee - Operating	$ 566,954	Lutheran Senior Services	100.00%	$ 569,092	$ 2,138	1
2	V	30	Management Fee - Capital		Lutheran Senior Services	100.00%	22,223	22,223	2
3	V	32	HO Excess Interest Income		Lutheran Senior Services	100.00%	(45,931)	(45,931)	3
4	V	4	Laundry	61,682	Lutheran Senior Services	100.00%	56,595	(5,087)	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			$ 628,636			$ 601,979	$ * (26,657)	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: 1/01/2016 Ending: 12/31/2016

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	Lutheran Hillside Village	Peoria, IL				1
2	Lee H. Bodendieck	BOD	REACH West County	Creve Coeur, MO				2
3	Diane R. Drollinger	BOD	St. Joseph Bluffs	Jefferson City. MO				3
4	Karl A. Dunajcik	BOD						4
5	Jeffrey L. Dunn	BOD						5
6	Scott M. Hartwig	BOD						6
7	John A. Komlos	BOD						7
8	John R. Kotovsky	BOD						8
9	Dr. F. Matt Kuhlmann	BOD						9
10	Harry Mueller	BOD						10
11	Kathleen T. Mueller	BOD						11
12	Olson, Gary	BOD						12
13	William F. Roth	BOD						13
14	Rev. Dr. Scott K. Seidler	BOD						14
15	Rev. William T. Simmons	BOD						15
16	Sherri C. Strand	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: 1/01/2016 Ending: 12/31/2016

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: 1/01/2016 Ending: 2/31/2016

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	Management - Operating	Direct Costs	209,168,678	24	$ 15,705,573	$ 11,097,416	7,579,237	$ 569,092	1
2	30	Management - Capital	Direct Costs	209,168,678	24	613,297		7,579,237	22,223	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					$ 16,318,870	$ 11,097,416		$ 591,315	25

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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	10/31/2010	6,958,280	6,553,431	2/01/2042	Variable	365,562	2
3	2007C Bonds						2,128,919	1,968,765				3
4	Interest Income										(52,451)	4
5	Bond Financing Costs										(6,572)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 9,087,199	$ 8,522,196			$ 306,539	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	$ 8,522,196			$ 306,539	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: 1/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 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.)	$	163,184	2
3. Under or (over) accrual (line 2 minus line 1).	$	163,184	3
4. Real Estate Tax accrual used for 2016 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.	$	163,184	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-1-15-28-00-000-005	PT N 1/2 NE	$ 135,345.80	$ 135,345.80
2.	14-1-15-28-00-000-005.001	PT N 1/2 NE	$ 85,649.28	$ 27,838.60
3.	14-1-15-28-00-000-005.002	PART NORTH 1/2 NORTHEAST	$ 281,775.72	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 502,770.80	$ 163,184.40

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 1/01/2016 Ending: 12/31/2016

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 operates 53 assisted living units, 14 assisted living memory care units, 129 independent living apartments, and 34 patio homes
(Meridian Village Association - Independent Living, 55,240 Square Feet; Meridian Village Association III - Assisted Living, 50,790 Square Feet, and Independent Living, 30,716 Square Feet)

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 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: 1/01/2016 Ending: 12/31/2016

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	$ 189,505	40	$ 189,505	$	$ 1,168,612	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2006	26,805	1,434	Various	1,434		20,353	9
10	Various			2007	14,905	994	15	994		9,440	10
11	PANELS,ACOUSTICAL			2008	3,721	248	15	248		2,109	11
12	CONDENSER-DINING AREA			2008	2,118	141	15	141		1,200	12
13	CORNER GUARDS			2008	1,257	84	15	84		713	13
14	PAINTING-501-524			2008	950		7			950	14
15	SOUND SYSTEM			2008	1,763	118	15	118		999	15
16	FLOORING,CARPET-LIVING RM			2009	2,077	148	7	148		2,077	16
17	A/C-HTG-PKG, 15000BTU-COMFORT-KITCHEN			2010	4,282	285	15	285		1,856	17
18	WIRING/ELECTRICAL-OPTIMUS			2010	3,240	216	15	216		1,404	18
19	ACCOUSTICAL SOUND TEST			2010	4,000	267	15	267		1,733	19
20	DOOR W/ KEY PA ENTRY-CC			2010	1,642	109	15	109		712	20
21	A/C&HT, 9,300 BTU			2010	1,176	78	15	78		510	21
22	FLOORING, CARPET			2010	530	76	7	76		492	22
23	DOOR RELEASE, HANDICAP TYPE-VINTAGE GARD			2010	3,052	203	15	203		1,323	23
24	PAINTING-RM TURNAROUNDS			2010	4,000	571	7	571		3,714	24
25	DOOR RELEASE, HANDICAP-COURTYARD ENTRA			2010	448	64	7	64		416	25
26	A/C, PTAC ISLANDAIRE,9300 BTU			2010	1,176	78	15	78		510	26
27	A/C, PTAC,ISLANDAIR,9300 BTU			2010	1,176	78	15	78		510	27
28	CABINETS, SPA			2010	1,073	72	15	72		465	28
29	ARCHITECTURAL CONSULTANT			2011	227	15	15	15		91	29
30	SIGNS, INTERIOR			2011	134	9	15	9		53	30
31	ARIAL SYSTEM UPGRADE			2011	4,867	324	15	324		1,893	31
32	DOOR, ACCORDIAN&INSTALLATION			2011	1,007	67	15	67		364	32
33	FLOORING, CARPET-COMMON AREAS,VINATAGE G			2011	16,433	2,348	7	2,348		12,325	33
34	ARCHITECTURAL CONSULTANT			2011	133	9	15	9		53	34
35	SIGNS, INTERIOR			2011	78	5	15	5		31	35
36	A/C, PTAC, 9300 BTU, ISLANDAIR			2012	4,704	314	15	314		1,568	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: 1/01/2016 Ending: 12/31/2016

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	$	$ 14,079	37
38	ELECTRICAL UPGRADES-DATA JACK	2012	874	58	15	58		252	38
39	ARCHITECT CONSULTANT	2013	3,900	98	40	98		391	39
40	FLOORING, CARPET-#98026	2013	951	190	5	190		681	40
41	A/C UNITS- VINTAGE GARDENS	2013	1,165	78	15	78		272	41
42	CAT-5 DATA DROP CC & VINTAGE GARDENS (3)	2013	4,367	291	15	291		1,067	42
43	FLOORING - VINYL - ROOM #524	2014	249	50	5	50		133	43
44	FLOORING-CARPET ROOM #512	2014	1,250	250	5	250		583	44
45	FLOORING-CARPET ROOM #628	2014	834	167	5	167		375	45
46	FLOORING-VINYL ROOM #512	2014	1,226	245	5	245		531	46
47	FLOORING-VINYL CAVE CTR	2015	3,399	486	7	486		971	47
48	CARPET #27-638	2015	948	190	5	190		363	48
49	CARPET #1-631	2015	957	191	5	191		335	49
50	CARPET #1-633	2015	957	191	5	191		335	50
51	COMMON AREA PLANK FLOORING	2015	941	134	7	134		235	51
52	CARPET #1-627	2015	932	186	5	186		326	52
53	FLOORING-CARPETING 243	2015	1,192	238	5	238		358	53
54	REPLACE CARE CENTER DOORS	2015	9,471	631	15	631		947	54
55	REPLACE EXIT DEVICE ON EXIT DOOR	2015	1,565	104	15	104		139	55
56	BLINDS FOR IL, C/C HALL, POOL	2015	2,000	133	15	133		178	56
57	UPGRADE 4 LOCKS WITH KEYPADS	2015	2,812	187	15	187		234	57
58	CABINETS FOR VINT GARDEN	2015	3,547	237	15	237		296	58
59	CABINETS FOR VINT GARDEN	2015	273	18	15	18		23	59
60	VINYL FLOORING UNIT 1-RETREAT	2015	2,309	330	7	330		385	60
61	VINYL FLOORING UNIT 1-MAIN DR.	2015	8,965	1,281	7	1,281		1,494	61
62	GE ZONELINE PTAC	2015	1,274	127	10	127		149	62
63	GE ZONELINE PTAC	2015	1,414	141	10	141		165	63
64	QTY 3 PTAC 12K BTU	2015	1,086	109	10	109		118	64
65	QTY 3 PTAC 12K BTU	2015	1,414	141	10	141		153	65
66	COUNTERTOP, VINTAGE GARDENS	2015	1,362	91	15	91		98	66
67	RM FINISHES FIXTURES, VINTAGE GARDENS	2015	176	12	15	12		13	67
68	RM FINISHES FIXTURES, VINTAGE GARDENS	2015	103	7	15	7		7	68
69	CARPET TO TILE REDUCERS	2016	849	142	5	142		142	69
70	TOTAL (lines 4 thru 69)		$ 6,502,494	$ 207,782		$ 207,782	$	$ 1,262,304	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: 1/01/2016 Ending: 12/31/2016

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	
1	Totals from Page 12A, Carried Forward		$ 6,502,494	$ 207,782		$ 207,782	$	$ 1,262,304	1
2	ceiling fans qty 2	2016	2,554	99	15	99		99	2
3	FRIEDRICH VEA SERIES VTAC QTY 3	2016	5,208	174	15	174		174	3
4	PAGER QTY 10	2016	1,597	44	15	44		44	4
5	CABLE FOR NETWORK E.H.R. PROJECT	2016	340	9	15	9		9	5
6	CABLE DROPS FOR E.H.R. NETWORK PROJ	2016	1,201	33	15	33		33	6
7	CARPET & V PLANK UNIT 437	2016	586	29	5	29		29	7
8	CARPET & V PLANK UNIT 480	2016	1,386	69	5	69		69	8
9	PAGER QTY 6	2016	952	16	15	16		16	9
10	CARPET UNIT 451	2016	2,042	68	5	68		68	10
11	PAGER QTY 6	2016	950	5	15	5		5	11
12	CABINETS & COUNTERTOP	2016	1,323	7	15	7		7	12
13	V PLANK UNIT 501	2016	1,748	29	5	29		29	13
14	V PLANK UNIT 507	2016	2,426	40	5	40		40	14
15	FRIEDRICH VTAC QTY 3	2016	5,208	29	15	29		29	15
16	rounding		1	5		5		(1)	16
17									17
18									18
19	HO Depreciation Allocation			22,223		22,223			19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,530,016	$ 230,661		$ 230,661	$	$ 1,262,954	34

**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: 1/01/2016 Ending: 12/31/2016

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	$ 923,436	$ 116,534	$ 116,534	$		$ 763,852	71
72	Current Year Purchases	408,928	43,052	43,052			43,052	72
73	Fully Depreciated Assets	111,964	564	564			111,964	73
74								74
75	TOTALS	$ 1,444,328	$ 160,150	$ 160,150	$		$ 918,868	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)	$ 8,650,478	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 390,811	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 390,811	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)	$ 2,235,557	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	$ 2,640	86
87	SNF Location (5140 and 5141)	469,109	33,579	13,409	87
88	Independent Living	39,618,785	1,469,794	16,904,943	88
89	Assisted Living	591,766	54,220	276,844	89
90	Assisted Living Dementia	545,685	39,301	303,542	90
91	TOTALS	$ 41,229,116	$ 1,597,145	$ 17,501,378	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: 1/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 9,672 Description: Nursing, Activties & A&G
(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: 1/01/2016 Ending: 12/31/2016

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)			Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	V10A-3	hrs	$	4,030	$	273,158	$	4,030	$ 273,158	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,675		109,338		1,675	109,338	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	V10A-3	hrs		3,711		245,341	26,365	3,711	271,706	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					357,395		357,395	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): Respiratory Therapy	V-39-2			348		17,400		348	17,400	12
13	Other (specify): Other (See WTB)						81,431	44,589		126,020	13
14	TOTAL			$	9,764	$	726,668	$ 428,349	9,764	$ 1,155,017	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Meridian Village Care Center **#** 0045807 **Report Period Beginning:** 1/01/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ (1,395,354)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (438,941))	1,746,937		3
4	Supply Inventory (priced at)	48,822		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	90,988		7
8	Accounts Receivable (owners or related parties)	(594)		8
9	Other(specify): Other Current Assets	39,554		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 530,353	$	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	44,322,082		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,016,063		16
17	Accumulated Depreciation (book methods)	(19,736,935)		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)**	$ 30,142,659	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 30,673,012	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 195,966	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	432,124		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,361		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	Other Current Liabilities	12,813		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 657,264	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	762,740		39
40	Mortgage Payable	36,459,399		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Entrance Fees Payable	8,833,222		43
44	Resident Deposits	322,432		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 46,377,793	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 47,035,057	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (16,362,045)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 30,673,012	$	48

***(See instructions.)**

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (15,765,065)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (15,765,065)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(596,970)	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**	(10)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (596,980)	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)**	$ (16,362,045)	24 *

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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	$ 7,898,374	1
2	Discounts and Allowances for all Levels	(2,818,987)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,079,387	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,729,622	6
7	Oxygen	5,947	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,735,569	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	50,655	13
14	Non-Patient Meals	110	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	466,017	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	50,334	19
20	Radiology and X-Ray	13,912	20
21	Other Medical Services	72,426	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 653,454	23
	D. Non-Operating Revenue		
24	Contributions	115,073	24
25	Interest and Other Investment Income***	4,099	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 119,172	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	76,255	28
28a	IL and AL Revenue	9,351,102	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,427,357	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,014,939	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	960,709	31
32	Health Care	2,992,472	32
33	General Administration	2,671,544	33
	B. Capital Expense		
34	Ownership	924,495	34
	C. Ancillary Expense		
35	Special Cost Centers	9,915,776	35
36	Provider Participation Fee	146,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,611,909	40
41	**Income before Income Taxes (line 30 minus line 40)****	(596,970)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (596,970)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 491,426	44
45	Private Pay - Net Inpatient Revenue	3,922,139	45
46	Medicare - Net Inpatient Revenue	570,638	46
47	Other-(specify) Benevolent Care	(213,338)	47
48	Other-(specify) Managed Care	308,522	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,079,387	49

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

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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	1,938	2,134	$ 89,655	$ 42.01	1
2	Assistant Director of Nursing			-		2
3	Registered Nurses	4,984	5,505	135,203	24.56	3
4	Licensed Practical Nurses	24,746	27,034	634,764	23.48	4
5	CNAs & Orderlies	70,569	77,675	1,105,642	14.23	5
6	CNA Trainees			-		6
7	Licensed Therapist			-		7
8	Rehab/Therapy Aides			-		8
9	Activity Director			-		9
10	Activity Assistants	7,308	7,664	140,671	18.35	10
11	Social Service Workers	2,011	2,011	52,238	25.98	11
12	Dietician			-		12
13	Food Service Supervisor			-		13
14	Head Cook			-		14
15	Cook Helpers/Assistants	17,553	19,175	236,424	12.33	15
16	Dishwashers			-		16
17	Maintenance Workers	4,010	4,197	80,949	19.29	17
18	Housekeepers	7,566	8,193	94,082	11.48	18
19	Laundry			-		19
20	Administrator	2,080	2,080	72,262	34.74	20
21	Assistant Administrator			-		21
22	Other Administrative	21,882	23,338	511,071	21.90	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	1,509	1,515	24,176	15.96	31
32	Other Health C: MARKETING	2,410	2,452	88,317	36.02	32
33	Other(specify) AL/IL	104,104	112,506	2,546,816	22.64	33
34	TOTAL (lines 1 - 33)	272,670	295,479	$ 5,812,270 *	$ 19.67	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		$		35
36	Medical Director	Monthly	24,000	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	80	5,871	V39-3	39
40	Physical Therapy Consultant	6	303	V10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	348	17,400	V39-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	419	V11-3	44
45	Social Service Consultant	58	3,787	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	506	$ 51,780		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: 1/01/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Drew Redman	Care Center Administrator		$ 90,848
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,848

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
Lutheran Senior Services	Management Services	$ 566,954
CliftonLarsonAllen LLP	Accounting Services	6,201
Polsinelli PC	Legal Services	1,172
Thompson Coburn LLP	Legal Services	326
SL Chapman LLC	Legal Services	11,260
Brown & James PC	Legal Services	12,801
Byron Carolson Petri & Kalb, LLC	Legal Services	15,764
Lashly & Baer, P.C.	Legal Services	208
Williams, Venker, & Sanders LLC	Legal Services	6,360
John J. Hopkins & Assoc., P.C.	Legal Services	2,831
United States Arbitrations and Media	Legal Services	358
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 624,235

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,331
Unemployment Compensation Insurance	8,779
FICA Taxes	238,364
Employee Health Insurance	342,978
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	1,262
Disability Insurance	6,841
Life Insurance	4,167
Savings & Revenue Sharing	45,492
Dental Insurance	19,432
Tuition Reimbursement	988
TOTAL (agree to Schedule V, line 22, col.8)	$ 718,634

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	$ 4,784
Advertising: Employee Recruitment	3,382
Health Care Worker Background Check	
(Indicate # of checks performed 873)	5,454
Patient Background Checks 455	9,696
Other Subscriptions/Publications/Licenses	1,325
LSN	5,613
Other Licenses	1,174
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,428

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,410
Seminar Expense	11,383
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,793

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/01/2016 Ending: 12/31/2016

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 - $5,613**

(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? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,502** 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. $ **146,913**
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. $ **110**

(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? **100**
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 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