FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Pl (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, CPA **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 1/1/2018 to 12/31/2018 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) Chad Sneed
(Title) Vice President of Financial Reporting & Budgeting

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: 1/1/2018 Ending: 12/31/2018

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 _____

	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	746	14,864	7,800	23,410	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	746	14,864	7,800	23,410	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.62%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 4,561

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	1,002,131	99,941	31,425	1,133,497	(748,910)	384,587		384,587			1
2	Food Purchase		815,128		815,128	(553,426)	261,702	(155)	261,547			2
3	Housekeeping	304,546	29,698	8,511	342,755	(220,589)	122,166		122,166			3
4	Laundry		5,169	43,046	48,215		48,215	(3,040)	45,175			4
5	Heat and Other Utilities			658,712	658,712	(563,707)	95,005	(10,902)	84,103			5
6	Maintenance	407,539	82,611	362,567	852,717	(729,732)	122,985	(710)	122,275			6
7	Other (specify):*											7
8	TOTAL General Services	1,714,216	1,032,547	1,104,261	3,851,024	(2,816,364)	1,034,660	(14,807)	1,019,853			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,450,542	98,591	40,762	2,589,895		2,589,895		2,589,895			10
10a	Therapy			860,067	860,067		860,067		860,067			10a
11	Activities	371,230	15,168	52,389	438,787	(354,443)	84,344	(1,350)	82,994			11
12	Social Services	68,078	180	2,781	71,039		71,039		71,039			12
13	CNA Training											13
14	Program Transportation	68,724	10,837	5,680	85,241	(68,856)	16,385	(954)	15,431			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,958,574	124,776	991,679	4,075,029	(423,299)	3,651,730	(2,304)	3,649,426			16
	C. General Administration											
17	Administrative	94,071			94,071		94,071		94,071			17
18	Directors Fees											18
19	Professional Services			870,057	870,057	(90,813)	779,244	(216,510)	562,734			19
20	Dues, Fees, Subscriptions & Promotions			42,111	42,111	(24,790)	17,321		17,321			20
21	Clerical & General Office Expenses	403,167	30,260	458,204	891,631	(514,641)	376,990	(202,981)	174,009			21
22	Employee Benefits & Payroll Taxes			487,316	487,316	167,630	654,946		654,946			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,535	13,535	(7,303)	6,232		6,232			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			67,875	67,875		67,875		67,875			26
27	Other (specify):* Marketing	124,020	20,637	228,373	373,030		373,030	(373,030)				27
28	TOTAL General Administration	621,258	50,897	2,167,471	2,839,626	(469,917)	2,369,709	(792,521)	1,577,188			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,294,048	1,208,220	4,263,411	10,765,679	(3,709,580)	7,056,099	(809,632)	6,246,467			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Meridian Village Care Center #0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			344,804	344,804		344,804	22,076	366,880			30
31	Amortization of Pre-Op. & Org.			(23,269)	(23,269)		(23,269)		(23,269)			31
32	Interest			364,649	364,649		364,649	(20,138)	344,511			32
33	Real Estate Taxes			177,651	177,651		177,651		177,651			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,790	3,790		3,790		3,790			35
36	Other (specify):*											36
37	**TOTAL Ownership**			867,625	867,625		867,625	1,938	869,563			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		368,609	88,871	457,480		457,480		457,480			39
40	Barber and Beauty Shops		176	36,593	36,769		36,769	(36,769)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			124,174	124,174		124,174		124,174			42
43	Other (specify):* AL & IL	1,048,342	43,873	4,868,068	5,960,283	3,709,580	9,669,863	(9,669,863)				43
44	**TOTAL Special Cost Centers**	1,048,342	412,658	5,117,706	6,578,706	3,709,580	10,288,286	(9,706,632)	581,654			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,342,390	1,620,878	10,248,742	18,212,010		18,212,010	(10,514,326)	7,697,684			45

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	(143)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,902)	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	(9,106)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(84,304)	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	(402)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(116,144)	21		24
25	Fund Raising, Advertising and Promotional	(373,030)	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	(9,711,939)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,305,970)		$	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)	(208,356)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (208,356)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (10,514,326)		37

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

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

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

Meridian Village Care Center

ID# 0045807

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Beauty Shop Income (limited to expense)	$ (36,769)	40	1
2	Transportation Income	(954)	14	2
3	Miscellaneous Income	(558)	21	3
4	Interest on Past Due Accounts	(150)	32	4
5	Maintenance Services Income	(710)	6	5
6	Misc Resident Reimb	(1,573)	21	6
7	Senior Fit	(1,335)	11	7
8	Cafeteria Income	(12)	2	8
9	Activity Income	(15)	11	9
10	AL & IL Expenses	(9,669,863)	43	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**	(9,711,939)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(155)	0	0	0	0	0	0	0	0	0	0	(155)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(3,040)	0	0	0	0	0	0	0	0	0	(3,040)	4
5	Heat and Other Utilities	(10,902)	0	0	0	0	0	0	0	0	0	0	(10,902)	5
6	Maintenance	(710)	0	0	0	0	0	0	0	0	0	0	(710)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,767)	(3,040)	0	0	0	0	0	0	0	0	0	(14,807)	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	(1,350)	0	0	0	0	0	0	0	0	0	0	(1,350)	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	(954)	0	0	0	0	0	0	0	0	0	0	(954)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,304)	0	0	0	0	0	0	0	0	0	0	(2,304)	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	(216,510)	0	0	0	0	0	0	0	0	0	(216,510)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(202,981)	0	0	0	0	0	0	0	0	0	0	(202,981)	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):*	(373,030)	0	0	0	0	0	0	0	0	0	0	(373,030)	27
28	**TOTAL General Administration**	(576,011)	(216,510)	0	0	0	0	0	0	0	0	0	(792,521)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(590,082)	(219,550)	0	0	0	0	0	0	0	0	0	(809,632)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	22,076	0	0	0	0	0	0	0	0	0	22,076	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,256)	(10,882)	0	0	0	0	0	0	0	0	0	(20,138)	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**	(9,256)	11,194	0	0	0	0	0	0	0	0	0	1,938	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	(36,769)	0	0	0	0	0	0	0	0	0	0	(36,769)	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):*	(9,669,863)	0	0	0	0	0	0	0	0	0	0	(9,669,863)	43
44	**TOTAL Special Cost Centers**	(9,706,632)	0	0	0	0	0	0	0	0	0	0	(9,706,632)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,305,970)	(208,356)	0	0	0	0	0	0	0	0	0	(10,514,326)	45

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Convalscent Home	Webster, MO	Lutheran Senior Servi	St. Louis, MO	Home Office
		Mason Pointe Care Center	Chesterfield, MO	In Home Services & H	St. Louis, MO	HHA/Hospice
		Breeze Park	St. Charles, MO	Richmond Terrace	Richmond Heights, MO	AL
		Heisinger Lutheran Home	Jefferson City, MO	Provident Group	St. Louis, MO	Mgt Co
		Lenoir Woods	Columbia, MO	Affordable Housing	St. Louis, MO	Housing
		Concordia Village Care Center	Springfield, IL	LSS Endownment Fun	St. Louis, MO	Foundation
		Meramec Bluffs	St. Louis, MO	Heisinger Hope Found	Jefferson City, MO	Foundation

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

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

1 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	$ 743,243	Lutheran Senior Services	100.00%	$ 526,733	$ (216,510)	1
2	V	30	Management Fee - Capital		Lutheran Senior Services	100.00%	22,076	22,076	2
3	V	32	HO Excess Interest Income		Lutheran Senior Services	100.00%	(10,882)	(10,882)	3
4	V	4	Laundry	26,949	Lutheran Senior Services	100.00%	23,909	(3,040)	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			$ 770,192			$ 561,836	$ * (208,356)	14

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Dan Brown	BOD	St. Joseph's Bluffs	Jefferson City, MO				2
3	Rev. Roy Christell	BOD						3
4	Diane R. Drollinger	BOD						4
5	Jeffery L. Dunn	BOD						5
6	Scott M. Hartwig	BOD						6
7	John A. Komlos	BOD						7
8	Rev. John R Kotovsky	BOD						8
9	Dr. F. Mathew Kuhlmann	BOD						9
10	Harry Mueller	BOD						10
11	Kathleen T. Mueller	BOD						11
12	Gary Olson	BOD						12
13	Lisa J. Sombart	BOD						13
14	Sherri C. Strand	BOD						14
15	Paul N. Tice	BOD						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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 Cost	240,344,604	24	$ 14,787,755	$ 12,655,470	8,560,900	$ 526,729	1
2	30	Management - Capital	Direct Cost	240,344,604	24	619,753		8,560,900	22,075	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					$ 15,407,508	$ 12,655,470		$ 548,804	25

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HO Excess Income Offset						$	$			$ (10,882)	1
2	2010 Bonds		X	Campus Expansion	Various	10/31/2010	6,958,280	6,198,618	2/1/2042	Variable	241,970	2
3	2007c Bonds		X				1,913,627	1,862,173			122,679	3
4	Interest Income										(9,106)	4
5	Interest Inc from Past Due accts		X								(150)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 8,871,907	$ 8,060,791			$ 344,511	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,871,907	$ 8,060,791			$ 344,511	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: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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.)	$	177,651	2
3. Under or (over) accrual (line 2 minus line 1).	$	177,651	3
4. Real Estate Tax accrual used for 2018 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.	$	177,651	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 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

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 152,073.24	$ 117,097.00
2.	14-1-15-28-00-000-005.001	PT N 1/2 NE	$ 78,640.52	$ 60,554.00
3.	14-1-15-28-00-000-005.02	Part North 1/2 NorthEast	$ 316,600.00	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 547,313.76	$ 177,651.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 assisited 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: 1/1/2018 Ending: 12/31/2018

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	$	$ 1,547,621	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2006	26,805	1,440	Various	1,440		23,219	9
10	Various			2007	14,905	994	15	994		11,427	10
11	Panels, Acoustical			2008	3,721	248	15	248		2,605	11
12	Condenser-Dining Area			2008	2,118	141	15	141		1,483	12
13	Corner Guards			2008	1,257	84	15	84		880	13
14	Painting-501-524			2008	950		7			950	14
15	Sound System			2008	1,763	118	15	118		1,234	15
16	Flooring, Carpet-Living Rm			2009	2,077		7			2,077	16
17	A/C-Htg-Pkg, 15000BTU-Comfort-Kitchen			2010	4,282	285	15	285		2,426	17
18	Wiring/Electric-Optimus			2010	3,240	216	15	216		1,836	18
19	Accoustical Sound Test			2010	4,000	267	15	267		2,267	19
20	Door w/ Key Pa Entry-CC			2010	1,642	109	15	109		930	20
21	A/C&Ht, 9,3000 BTU			2010	1,176	78	15	78		666	21
22	Flooring, Carpet			2010	530		7			530	22
23	Door Release, Handicap Type-Vintage Gard			2010	3,052	203	15	203		1,729	23
24	Painting-Rm Turnarounds			2010	4,000		7			4,000	24
25	Door Release, Handicap Type-Courtyard Entra			2010	448		7			448	25
26	A/C, PTAC, Islandaire, 9300 BTU			2010	1,176	78	15	78		666	26
27	A/C, PTAC, Islandair, 9300 BTU			2010	1,176	78	15	78		666	27
28	Cabinets, Spa			2010	1,073	72	15	72		608	28
29	Architrectural Consultant			2011	227	15	15	15		121	29
30	Signs, Interior			2011	134	9	15	9		71	30
31	Arial System Upgrade			2011	4,867	324	15	324		2,542	31
32	Door, Accordian & Installation			2011	1,007	67	15	67		498	32
33	Flooring, Carper-Common Areas, Vintage G			2011	16,433	1,761	7	1,761		16,433	33
34	Architectural Consultant			2011	133	9	15	9		71	34
35	Signs Interior			2011	78	5	15	5		42	35
36	A/C, PTAC, 9300BTU, Islandair			2012	4,704	314	15	314		2,195	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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		$ 3,188	$	$ 20,455	37
38	Eletrical Upgrades-Data Jack	2012	874	58		58		369	38
39	Flooring, Carpet-#98026	2013	951	79		79		951	39
40	A/C Units- Vintage Gardens	2013	1,165	78		78		427	40
41	Cat-5 Data Drop CC & Vintage Gardens (3)	2013	4,367	291		291		1,650	41
42	Vinyl #524	2014	249	50		50		232	42
43	Flooring-Carpet #512	2014	1,250	250		250		1,083	43
44	Flooring-Carpet #628	2014	834	167		167		709	44
45	Flooring-Vinyl #512	2014	1,226	245		245		1,022	45
46	Flooring-Vinyl Cave Ctr	2015	3,399	486		486		1,942	46
47	Carpet #27-638	2015	948	190		190		743	47
48	Carpet #1-631	2015	957	191		191		718	48
49	Carpet #1-633	2015	957	191		191		718	49
50	Common Area Plank Flooring	2015	941	134		134		504	50
51	Carpet #1-627	2015	932	186		186		699	51
52	Flooring Carpeting 243	2015	1,192	238		238		834	52
53	Replace Care Center Doors	2015	9,471	631		631		2,210	53
54	Replace Exit Drive on Exit Door	2015	1,565	104		104		348	54
55	Blinds for IL, C/C Hall, Pool	2015	2,000	133		133		444	55
56	Upgrade 4 Locks with Keypads	2015	2,812	187		187		609	56
57	Cabinets for Vint Garden	2015	3,547	237		237		769	57
58	Cabinets for Vint Garden	2015	273	18		18		59	58
59	Vinyl Flooring Unit 1-Retreat	2015	2,309	330		330		1,045	59
60	Vinyl Flooring Unit 1-Main Dr.	2015	8,965	1,281		1,281		4,055	60
61	GE Zoneline PTAC	2015	1,274	127		127		403	61
62	GE Zoneline PTAC	2015	1,414	141		141		448	62
63	Qty 3 PTAC 12k BTU	2015	1,086	109		109		335	63
64	Qty 3 PTAC 12k BTU	2015	1,414	141		141		436	64
65	Countertop, Vintage Gardens	2015	1,362	91		91		280	65
66	Rm Finishes Fixtures, Vintage Gardens	2015	176	12		12		36	66
67	Rm Finishes Fixtures, Vintage Gardens	2015	103	7		7		21	67
68	Carpet to Tile Reducers	2016	849	170		170		481	68
69	Ceiling Fans Qty 2	2016	2,554	170		170		440	69
70	TOTAL (lines 4 thru 69)		$ 6,501,148	$ 206,331		$ 206,331	$	$ 1,675,716	70

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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		$ 6,501,148	$ 206,331		$ 206,331	$	$ 1,675,716	1
2	Friedrich Vea Series Vtac Qty 3	2016	5,208	347	15	347		868	2
3	Pager Qty 10	2016	1,597	106	15	106		257	3
4	Cable For Network E.H.R. Project	2016	340	23	15	23		55	4
5	Cable Drops For E.H.R. Network Proj	2016	1,201	80	15	80		194	5
6	Carpet & V Plank Unity 437	2016	586	117	5	117		264	6
7	Carpet & V Plank Unity 480	2016	1,386	277	5	277		624	7
8	Pager Qty 6	2016	952	63	15	63		143	8
9	Carpet Unit 451	2016	2,042	408	5	408		885	9
10	Pager Qty 6	2016	950	63	15	63		132	10
11	Cabinets & Countertop	2016	1,323	88	15	88		184	11
12	V Plank Unit 501	2016	1,748	350	5	350		729	12
13	V Plank Unit 507	2016	2,426	485	5	485		1,011	13
14	Friedrich VTAC Qty 3	2016	5,208	347	15	347		723	14
15	Vinyl Plank Flooring	2016	881	176	5	176		176	15
16	Vinyl Flooring Unit 513	2017	430	86	5	86		93	16
17	Vinyl Plank Flooring	2017	702	140	5	140		152	17
18	Carpet Unit 609	2017	1,105	221	5	221		258	18
19	Vinyl Flooring Unit 517	2017	463	93	5	93		108	19
20	Vinyl Flooring Unit 510	2017	397	79	5	79		106	20
21	Carpet-Care Ctr Common Area	2017	1,450	207	7	207		276	21
22	Flooring Rm 520	2017	828	166	5	166		235	22
23	PTAC S#AH110279 Unit 511	2017	692	69	10	69		121	23
24	PTAC S#AH110278 CC Res Room 405	2017	692	69	10	69		121	24
25	PTAC S#AH110276 CC Rem Room 417	2017	692	69	10	69		121	25
26	PTAC S#AH110277 CC Res Room	2017	692	69	10	69		121	26
27	PTAC S#AH110177 CC Res Room	2017	692	69	10	69		121	27
28	PTAC S#HF367642 CC Res Room	2017	692	69	10	69		121	28
29	Secure Care Wandering System	2017	11,962	797	15	797		1,462	29
30	Vinyl Plank Flooring	2018	881	176	5	176		176	30
31	Vinyl Flooring Unit 505	2018	348	70	5	70		70	31
32	V Plank Flooring- Vintage Gardens	2018	670	123	5	123		123	32
33	V Plank Flooring-VG Rm 518	2018	718	132	5	132		132	33
34	TOTAL (lines 1 thru 33)		$ 6,551,102	$ 211,965		$ 211,965	$	$ 1,685,878	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: 1/1/2018 Ending: 12/31/2018

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 12B, Carried Forward		$ 6,551,102	$ 211,965		$ 211,965	$	$ 1,685,878	1
2	Vinyl Plank Flooring	2018	951	111		111		111	2
3									3
4	HO Depreciation Allocation			22,076		22,076			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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,552,053	$ 234,152		$ 234,152	$	$ 1,685,989	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: 1/1/2018 Ending: 12/31/2018

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	$ 1,974,261	$ 125,439	$ 125,439	$	Various	$ 1,693,238	71
72	Current Year Purchases	37,356	3,243	3,243		Various	3,243	72
73	Fully Depreciated Assets	755,591	2,816	2,816			755,591	73
74								74
75	TOTALS	$ 2,767,208	$ 131,498	$ 131,498	$		$ 2,452,072	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	Maintenance	2018 Ford transit 350	2018	51,556	1,230	1,230		7	1,230	77
78										78
79										79
80	TOTALS			$ 105,291	$ 1,230	$ 1,230	$		$ 54,965	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)	$ 10,046,951	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 366,880	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 366,880	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)	$ 4,193,026	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 Rennovated - 2006	$ 3,771	$ 251	$ 3,143	86
87	Independent Living	39,807,765	1,500,921	18,579,656	87
88	Assisted Living	792,650	79,281	426,705	88
89	Assisted Living Memory Care	553,139	35,563	374,305	89
90					90
91	TOTALS	$ 41,157,325	$ 1,616,016	$ 19,383,809	91

G. Construction-in-Progress

	Description	Cost	
92	CIP- Other	$ 127,027	92
93	CIP- Apt Unit Reno	10,191	93
94			94
95		$ 137,218	95

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 3,790 Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.

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	$	5,445	$ 346,212	$	5,445	$ 346,212	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,197	75,113		1,197	75,113	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		6,969	438,742		6,969	438,742	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				278,274		278,274	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Billable Supplies and B	V39-2					90,335		90,335	12
13	Other (specify): Lab, Xray, Hospital	V39-3				88,871			88,871	13
14	TOTAL			$	13,611	$ 948,938	$ 368,609	13,611	$ 1,317,547	14

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

STATE OF ILLINOIS

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 3,560,345	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (128,100))	605,175		3
4	Supply Inventory (priced at)	46,001		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	80,585		8
9	Other(specify): Other Current Assets	117,232		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,409,338	$	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	45,304,832		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,357,995		16
17	Accumulated Depreciation (book methods)	(23,554,759)		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 (spe Notes Receivable	81,200		22
23	Other(specify): CIP	137,218		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 27,867,935	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 32,277,273	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 329,594	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	517,930		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,718		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	Current Long Term Debt	3,867,521		36
37	Other Current Liabilities	213,122		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,948,885	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	31,695,464		43
44	Entrance fees payable and resident deposit	11,587,797		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 43,283,261	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 48,232,146	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (15,954,873)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 32,277,273	$	48

*(See instructions.)

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$		1
2	Restatements (describe):		(16,449,240)	2
3				3
4				4
5				5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	(16,449,240)	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		494,363	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe) **Rounding**		4	15
16	Other (describe)			16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	494,367	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)**	$	(15,954,873)	24 *

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 8,753,098	1
2	Discounts and Allowances for all Levels	(3,360,494)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,392,604	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,358,628	6
7	Oxygen	602	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,359,230	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	46,854	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	414,167	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	83,839	19
20	Radiology and X-Ray	19,560	20
21	Other Medical Services	60,553	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 624,973	23
	D. Non-Operating Revenue		
24	Contributions	190,450	24
25	Interest and Other Investment Income***	9,106	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 199,556	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Recenue	4,479	28
28a	IL and AL Revenue	10,125,531	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,130,010	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,706,373	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,851,024	31
32	Health Care	4,075,029	32
33	General Administration	2,839,626	33
	B. Capital Expense		
34	Ownership	867,625	34
	C. Ancillary Expense		
35	Special Cost Centers	6,578,706	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,212,010	40
41	**Income before Income Taxes (line 30 minus line 40)****	494,363	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 494,363	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 183,032	44
45	Private Pay - Net Inpatient Revenue	4,302,911	45
46	Medicare - Net Inpatient Revenue	2,606,963	46
47	Other-(specify) Managed Care	1,660,192	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,753,098	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: 1/1/2018 Ending: 12/31/2018

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	1,904	2,080	$ 91,769	$ 44.12	1
2	Assistant Director of Nursing	1,889	2,100	68,017	32.39	2
3	Registered Nurses	4,509	5,154	162,847	31.60	3
4	Licensed Practical Nurses	25,504	28,535	745,361	26.12	4
5	CNAs & Orderlies	68,456	75,991	1,216,668	16.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,380	6,896	122,478	17.76	10
11	Social Service Workers	3,272	3,272	61,325	18.74	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,905	28,642	386,091	13.48	15
16	Dishwashers					16
17	Maintenance Workers	4,479	4,741	85,015	17.93	17
18	Housekeepers	6,822	7,461	94,162	12.62	18
19	Laundry					19
20	Administrator	1,866	2,080	94,071	45.23	20
21	Assistant Administrator					21
22	Other Administrative	1,038	1,107	28,841	26.05	22
23	Office Manager					23
24	Clerical	11,981	12,472	324,892	26.05	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	1,666	1,666	33,295	19.98	31
32	Other Health C: MDS Coordinator	1,072	1,242	38,514	31.01	32
33	Other(specify) AL & IL	166,824	179,061	2,789,044	15.58	33
34	TOTAL (lines 1 - 33)	334,567	362,500	$ 6,342,390 *	$ 17.50	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	30,000	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	99	9,441	V39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	42	2,781	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	141	$ 42,222		49

C. CONTRACT NURSES

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sarah Burch	Administrator	0	$ 94,071
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,071

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	$ 743,243
CliftonLarsonAllen LLP	Audit/Tax/Cost Report	7,750
Polsinelli PC	Legal	6,641
Various	Data Processing	112,423
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 870,057

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,250
Unemployment Compensation Insurance	22,025
FICA Taxes	242,347
Employee Health Insurance	310,529
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	7,919
Life Insurance	4,611
Savings & Revenue Sharing	21,186
Dental Insurance	17,079
TOTAL (agree to Schedule V, line 22, col.8)	$ 654,946

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	$ 569
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 397)	
Patient Background Checks	2,584
Subscriptions	1,804
Dues and Memberships	185
Leading Age	8,368
Licenses	3,811
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,321

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,677
Seminar Expense	4,555
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,232

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. **Leading Age, $8368**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,273** 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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **124,174**
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? **No** Indicate the amount. $ **0**

(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?
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