



Facility Name & ID Number Meridian Village Care Center

# 0045807 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>32</u>	Skilled (SNF)	<u>56</u>	<u>13,096</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>32</u>	TOTALS	<u>56</u>	<u>13,096</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	Private Pay	4 Other			
8	SNF	<u>1,666</u>	<u>9,805</u>	<u>36</u>	<u>11,507</u>	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>1,666</u>	<u>9,805</u>	<u>36</u>	<u>11,507</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.87%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 12/19/2005

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 3/30/2005 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 56 and days of care provided 36

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	161,332	5,590	2,258	169,180		169,180	(231)	168,949		1
2	Food Purchase		73,271		73,271		73,271		73,271		2
3	Housekeeping	30,614	3,571	390	34,575		34,575		34,575		3
4	Laundry	1,687	1,220	10,303	13,210		13,210	(171)	13,039		4
5	Heat and Other Utilities			1,205	1,205		1,205		1,205		5
6	Maintenance	27,085	5,486	34,890	67,461		67,461		67,461		6
7	Other (specify):* <b>Waste Disposal</b>			2,887	2,887		2,887		2,887		7
8	<b>TOTAL General Services</b>	220,718	89,138	51,933	361,789		361,789	(402)	361,387		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	887,068	31,431	29,736	948,235		948,235		948,235		10
10a	Therapy	9,327	5,608		14,935		14,935		14,935		10a
11	Activities	88,699	15,477	6,515	110,691		110,691		110,691		11
12	Social Services	33,672	398	1,464	35,534		35,534		35,534		12
13	CNA Training										13
14	Program Transportation	17,361	4,335	2,385	24,081		24,081		24,081		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,036,127	57,249	52,100	1,145,476		1,145,476		1,145,476		16
	<b>C. General Administration</b>										
17	Administrative	95,123			95,123		95,123		95,123		17
18	Directors Fees										18
19	Professional Services			264,095	264,095		264,095	(112,670)	151,425		19
20	Dues, Fees, Subscriptions & Promotions			15,113	15,113		15,113		15,113		20
21	Clerical & General Office Expenses	97,730	12,615	(257,689)	(147,344)		(147,344)	(15,983)	(163,327)		21
22	Employee Benefits & Payroll Taxes			399,593	399,593		399,593		399,593		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,636	14,636		14,636		14,636		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			25,346	25,346		25,346		25,346		26
27	Other (specify):* <b>Marketing</b>	13,355	7,252	12,081	32,688		32,688	(32,688)			27
28	<b>TOTAL General Administration</b>	206,208	19,867	473,175	699,250		699,250	(161,341)	537,909		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,463,053	166,254	577,208	2,206,515		2,206,515	(161,743)	2,044,772		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Meridian Village Care Center

#0045807

Report Period Beginning: 01/01/2010 Ending: 12/31/2010

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			74,920	74,920		74,920	65,830	140,750			30
31	Amortization of Pre-Op. & Org.			232	232		232		232			31
32	Interest			380,525	380,525		380,525		380,525			32
33	Real Estate Taxes			39,179	39,179		39,179		39,179			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			494,856	494,856		494,856	65,830	560,686			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,806	7,519	54,325		54,325		54,325			39
40	Barber and Beauty Shops			7,161	7,161		7,161	(7,161)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			17,741	17,741		17,741		17,741			42
43	Other (specify):* <b>IL/AL and Chaplaincy</b>			6,317,686	6,317,686		6,317,686	(6,317,686)				43
44	<b>TOTAL Special Cost Centers</b>		46,806	6,350,107	6,396,913		6,396,913	(6,324,847)	72,066			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,463,053	213,060	7,422,171	9,098,284		9,098,284	(6,420,760)	2,677,524			45

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

**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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(231)	1		4
5	Telephone, TV & Radio in Resident Rooms	(9,375)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				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	(761)	21		24
25	Fund Raising, Advertising and Promotional	(32,688)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,505,356)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (6,548,411)</b>		<b>\$</b>	<b>30</b>

**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	2	
		Amount	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)	127,651	VII-B	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 127,651</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (6,420,760)</b>		<b>37</b>

\*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	2	3	4
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

BHF USE ONLY							
48		49		50		51	52

Meridian Village Care Center

ID# 0045807

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Barber & Beauty Revenue	\$ (7,161)	40	1
2	Miscellaneous Revenue	(5,847)	21	2
3	IL, AL and Chaplaincy Expenses	(6,317,686)	43	3
4	CCIC Reimbursement	(174,662)	19	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				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	<b>Total</b>	(6,505,356)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Meridian Village Care Center

# 0045807

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

## 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)	
	<b>A. General Services</b>													
1	Dietary	(231)	0	0	0	0	0	0	0	0	0	0	(231)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(171)	0	0	0	0	0	0	0	0	0	(171)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(231)</b>	<b>(171)</b>	<b>0</b>	<b>(402)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(174,662)	61,992	0	0	0	0	0	0	0	0	0	(112,670)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(15,983)	0	0	0	0	0	0	0	0	0	0	(15,983)	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):*	(32,688)	0	0	0	0	0	0	0	0	0	0	(32,688)	27
28	<b>TOTAL General Administration</b>	<b>(223,333)</b>	<b>61,992</b>	<b>0</b>	<b>(161,341)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(223,564)</b>	<b>61,821</b>	<b>0</b>	<b>(161,743)</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meridian Village Care Center# 0045807

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	65,830	0	0	0	0	0	0	0	0	0	65,830	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>0</b>	<b>65,830</b>	<b>0</b>	<b>65,830</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(7,161)	0	0	0	0	0	0	0	0	0	0	(7,161)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(6,317,686)	0	0	0	0	0	0	0	0	0	0	(6,317,686)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(6,324,847)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,324,847)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(6,548,411)	127,651	0	0	0	0	0	0	0	0	0	(6,420,760)	45

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Listing of Board Members				Lutheran Senior Servi	St. Louis, MO	Home Office
				Meridian Village Assoc	Glen Carbon, IL	CCRC

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Management Fees	\$ 109,482	Lutheran Senior Services	100.00%	\$ 171,474	\$ 61,992	1
2	V	4 Laundry	10,246	Lutheran Senior Services	100.00%	10,075	(171)	2
3	V	30 Depreciation		Meridian Village Association II		65,830	65,830	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 119,728			\$ 247,379	\$ * 127,651	14

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Meridian Village Care Center

# 0045807

Report Period Beginning:

01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Home Office	Direct Costs	27	\$ 8,444,182	\$ 0	109,482	\$ 109,482	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 8,444,182	\$		\$ 109,482	25

Facility Name & ID Number

Meridian Village Care Center

# 0045807

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

**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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Missouri HEFA					\$		\$		1									
2	2010 Bonds	X	Campus Expansion	Various	Oct 2010	6,938,394	6,938,394	Feb 2042	Variable	380,526									
3										3									
4										4									
5										5									
<b>Working Capital</b>																			
6										6									
7										7									
8										8									
9	<b>TOTAL Facility Related</b>					\$ 6,938,394	\$ 6,938,394			\$ 380,526									
<b>B. Non-Facility Related*</b>																			
10										10									
11										11									
12										12									
13										13									
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$									
15	<b>TOTALS (line 9+line14)</b>					\$ 6,938,394	\$ 6,938,394			\$ 380,526									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ 4,687      Line # 32

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2009 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.)		\$	<b>39,178</b>	2															
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>39,178</b>	3															
4. Real Estate Tax accrual used for 2010 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6															
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>39,178</b>	7															
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2005	_____	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2009 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2009 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2009 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2006	_____	9																
	2007	_____	10																
	2008	_____	11																
	2009	_____	12																

**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.**



Facility Name & ID Number Meridian Village Care Center

# 0045807

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 14,150 B. General Construction Type: Exterior Brick & Siding Frame Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

Meridian Village Association - Independent Living, 55,240 Square Feet, 99 units

Meridian Village Association III, Assisted Living, 50,246 Square Feet, 66 Units

Meridian Village Association III, Independent Living, 63 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Senior Living Facility</u>		<u>2003</u>	<u>\$ 783,851</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 783,851</b>	<b>3</b>

Facility Name &amp; ID Number Meridian Village Care Center

# 0045807

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	32		2005		\$ 1,669,454	\$ 62,682	30	\$ 62,682		\$ 369,922	4
5	24		2010		6,310,444	31,584	30	31,584		31,584	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Call Station with lights	2006		1,158	77	15	77		347	9
10		Emergency Lights	2006		2,461	164	15	164		738	10
11		Door Delays	2006		3,296	220	15	220		989	11
12		Walls in oxygen room	2006		2,581	172	15	172		774	12
13		Door Upgrades	2006		1,324	88	15	88		397	13
14		Fire Doors and hardware	2006		383	26	15	26		115	14
15		Wall covering	2006		5,135	342	15	342		1,540	15
16		Mixing Valve	2006		5,175	345	15	345		1,553	16
17		Carpet	2006		3,816	545	7	545		2,453	17
18		Vinyl Flooring	2006		1,478	211	7	211		950	18
19		Smoke and fire walls *****	2006		9,590	331	29	331		1,489	19
20		Exit Signs Installed	2007		1,179	79	15	79		275	20
21		Cables moved and installed	2007		205	14	15	14		48	21
22		Light Exterior Soffit	2007		697	46	15	46		162	22
23		Smoke detectors	2007		6,951	463	15	463		1,622	23
24		Door Hold with Fire alarm	2007		1,005	67	15	67		235	24
25		Plumbing work	2007		4,868	325	15	325		1,136	25
26		PANELS,ACOUSTICAL	2008		3,721	248	15	248		620	26
27		CONDENSER-DINING AREA	2008		2,118	141	15	141		353	27
28		CORNER GUARDS	2008		1,257	84	15	84		210	28
29		PAINTING-501-524	2008		950	136	7	136		340	29
30		SOUND SYSTEM	2008		1,763	118	15	118		294	30
31		FLOORING,CARPET-LIVING RM	2009		2,077	296	7	296		443	31
32		A/C-HTG-PKG, 15000BTU-COMFORT-KITCHEN	2010		4,282	143	15	143		143	32
33		WIRING/ELECTRICAL-OPTIMUS	2010		3,240	108	15	108		108	33
34		ACCOUSTICAL SOUND TEST	2010		4,000	133	15	133		133	34
35		DOOR W/ KEY PA ENTRY-CC	2010		1,642	55	15	55		55	35
36		A/C&HT, 9,300 BTU	2010		1,176	39	15	39		39	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 FLOORING, CARPET	2010	\$ 530	\$ 38	7	\$ 38	\$	\$ 38	37
38 DOOR RELEASE, HANDICAP TYPE-VINTAGE GARD	2010	3,052	102	15	102		102	38
39 PAINTING-RM TURNAROUNDS	2010	4,000	286	7	286		286	39
40 DOOR RELEASE, HANDICAP-COURTYARD ENTRA	2010	448	32	7	32		32	40
41 A/C, PTAC ISLANDAIRE,9300 BTU	2010	1,176	39	15	39		39	41
42 A/C, PTAC,ISLANDAIR,9300 BTU	2010	1,176	39	15	39		39	42
43 CABINETS, SPA	2010	1,073	36	15	36		36	43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 8,068,881	\$ 99,853		\$ 99,853	\$	\$ 419,639	70

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

Facility Name & ID Number Meridian Village Care Center

# 0045807

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 158,381	\$ 22,648	\$ 22,648	\$	7	\$ 116,343	71
72	Current Year Purchases	592,066	16,696	16,696		7	16,696	72
73	Fully Depreciated Assets	15,661	1,553	1,553			15,661	73
74								74
75	TOTALS	\$ 766,108	\$ 40,897	\$ 40,897	\$		\$ 148,700	75

D. Vehicle Depreciation (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 4X4 Truck	2005	\$ 29,831	\$	\$	\$	4	\$ 29,831	76
77										77
78										78
79										79
80	TOTALS			\$ 29,831	\$	\$	\$		\$ 29,831	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)	\$ 9,648,671	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 140,750	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 140,750	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)	\$ 598,170	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Common Area Renovated- 2006	\$ 3,771	\$ 251	\$ 1,131	86
87	Site Improvements	1,747,377	88,791	409,865	87
88	Marketing	4,457	637	3,502	88
89	Non Care Related Building	16,664,814	533,296	3,071,395	89
90	Non Care Related Equipment	905,066	135,617	563,667	90
91	TOTALS	\$ 19,325,485	\$ 758,592	\$ 4,049,560	91

G. Construction-in-Progress

	Description	Cost	
92	Care Center Renovations	\$ 33,374	92
93			93
94			94
95		\$ 33,374	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Not applicable - Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

If NO, see instructions.

		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	<b>TOTAL</b>				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2011</u>	\$ _____
13.	<u>/2012</u>	\$ _____
14.	<u>/2013</u>	\$ _____

\* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	V10A-3	hrs	\$	22	\$ 1,182				22	\$ 1,182					1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs													2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	V10A-3	hrs		27	1,545			509	27	2,054					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						5,680		5,680					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify):															12
13	Other (specify):															13
14	TOTAL			\$	49	\$ 2,727			\$ 6,189	49	\$ 8,916					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 &amp; ID Number Meridian Village Care Center

# 0045807

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,529,595	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 1,000 )	53,037		3
4	Supply Inventory (priced at Cost )	46,815		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	34,457		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Miscellaneous Receivable</u>	626		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,664,530	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	622,399		13
14	Buildings, at Historical Cost	11,340,009		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,108,661		16
17	Accumulated Depreciation (book methods)	(992,694)		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): <u>Construction in Progress</u>	33,374		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 12,111,749	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 14,776,279	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 56,473	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	197,991		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,006		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
	<b>Other Current Liabilities(specify):</b>			
36	<u>Refund Clearing Account</u>	2,029		36
37	<u>Due to LCFS</u>	47,553		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 309,052	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due to Related Party - LSS</u>	15,089,174		43
44	<u>Entrance Fees and Resident Deposits</u>	4,103,200		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 19,192,374	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 19,501,426	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (4,725,147)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 14,776,279	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(4,164,771)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(4,164,771)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(560,376)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(560,376)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(4,725,147)</b>	<b>24</b> *

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

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,142,970	1
2	Discounts and Allowances for all Levels	(175,735)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,967,235	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,565	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 6,565	8
<b>C. Other Operating Revenue</b>			
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	8,642	13
14	Non-Patient Meals	231	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,865	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	16	19
20	Radiology and X-Ray		20
21	Other Medical Services	51,812	21
22	Laundry	5,520	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 70,086	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	60,000	24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 60,000	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>CCIC Reimbursement, Senior Fit, Past Due Charges, and</b>	180,469	28
28a	<b>Independent and Assisted Living</b>	6,253,553	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,434,022	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,537,908	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	361,789	31
32	Health Care	1,145,476	32
33	General Administration	699,250	33
<b>B. Capital Expense</b>			
34	Ownership	494,856	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	6,396,913	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,098,284	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(560,376)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (560,376)	43

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,952	2,032	\$ 69,509	\$ 34.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,800	8,639	225,737	26.13	3
4	Licensed Practical Nurses	8,955	10,023	195,430	19.50	4
5	CNAs & Orderlies	29,988	33,577	380,808	11.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	888	968	9,327	9.64	8
9	Activity Director					9
10	Activity Assistants	7,690	8,625	106,059	12.30	10
11	Social Service Workers	1,761	1,862	33,672	18.08	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	10,720	11,668	161,332	13.83	15
16	Dishwashers					16
17	Maintenance Workers	1,501	1,632	27,085	16.60	17
18	Housekeepers	3,087	3,402	30,614	9.00	18
19	Laundry	150	189	1,687	8.93	19
20	Administrator	541	597	22,547	37.77	20
21	Assistant Administrator	2,352	2,352	72,576	30.86	21
22	Other Administrative	6,042	6,788	97,730	14.40	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,336	1,500	15,585	10.39	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	577	633	13,355	21.10	33
34	TOTAL (lines 1 - 33)	85,340	94,487	\$ 1,463,053 *	\$ 15.48	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	150	\$ 8,232	V1-3	35
36	Medical Director	Monthly	12,000	V9-3	36
37	Medical Records Consultant	20	1,200	V10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	103	6,711	V39-3	39
40	Physical Therapy Consultant	41	2,246	V10-a	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	542	V11-3	44
45	Social Service Consultant	22	1,384	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	344	\$ 32,315		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	98	\$ 8,534	V10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	98	\$ 8,534		53





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**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network - \$5116
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,566 Line 39
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 17,741  
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. \$ 231
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: LarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.