

Facility Name & ID Number Meridian Village Care Center

0045807 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,220	14,345	7,657	23,222	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,220	14,345	7,657	23,222	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.89%

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 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 70 and days of care provided 4,271

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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
	A. General Services										
1	Dietary	106,986	4,961	26,803	138,750	(348)	138,402	(2)	138,400		1
2	Food Purchase		172,978		172,978		172,978	(1,443)	171,535		2
3	Housekeeping	45,458	4,551	8,598	58,607		58,607		58,607		3
4	Laundry		4,307	62,628	66,935		66,935	(5,329)	61,606		4
5	Heat and Other Utilities			153,868	153,868		153,868	(38,510)	115,358		5
6	Maintenance	79,071	19,628	84,495	183,194	989	184,183	(8,466)	175,717		6
7	Other (specify):*										7
8	TOTAL General Services	231,515	206,425	336,392	774,332	641	774,973	(53,750)	721,223		8
	B. Health Care and Programs										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	2,318,911	59,256	16,614	2,394,781	(6,279)	2,388,502		2,388,502		10
10a	Therapy			643,259	643,259		643,259		643,259		10a
11	Activities	144,850	17,503	24,736	187,089	(5,049)	182,040	(1,399)	180,641		11
12	Social Services	60,422		3,442	63,864		63,864		63,864		12
13	CNA Training										13
14	Program Transportation	8,306	1,385	1,166	10,857		10,857	(127)	10,730		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,532,489	78,144	719,217	3,329,850	(11,328)	3,318,522	(1,526)	3,316,996		16
	C. General Administration										
17	Administrative	85,572			85,572		85,572		85,572		17
18	Directors Fees										18
19	Professional Services			648,214	648,214		648,214	(109,974)	538,240		19
20	Dues, Fees, Subscriptions & Promotions			19,485	19,485	6,367	25,852		25,852		20
21	Clerical & General Office Expenses	232,289	21,660	538,847	792,796	(2,925)	789,871	(519,354)	270,517		21
22	Employee Benefits & Payroll Taxes			672,048	672,048		672,048		672,048		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,560	11,560	2,628	14,188		14,188		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			53,668	53,668		53,668		53,668		26
27	Other (specify):* Marketing	49	8,690	167,663	176,402		176,402	(176,402)			27
28	TOTAL General Administration	317,910	30,350	2,111,485	2,459,745	6,070	2,465,815	(805,730)	1,660,085		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,081,914	314,919	3,167,094	6,563,927	(4,617)	6,559,310	(861,006)	5,698,304		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:

1/1/2017

Ending:

12/31/2017

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	
	D. Ownership											
30	Depreciation			415,021	415,021		415,021	20,263	435,284			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			336,047	336,047		336,047	(192,838)	143,209			32
33	Real Estate Taxes			167,731	167,731		167,731		167,731			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					4,617	4,617		4,617			35
36	Other (specify):*											36
37	TOTAL Ownership			918,799	918,799	4,617	923,416	(172,575)	750,841			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		379,998	99,292	479,290		479,290		479,290			39
40	Barber and Beauty Shops			35,615	35,615		35,615	(35,615)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			141,825	141,825		141,825		141,825			42
43	Other (specify):* IL and AL	2,883,704	816,539	5,975,447	9,675,690		9,675,690	(9,675,690)				43
44	TOTAL Special Cost Centers	2,883,704	1,196,537	6,252,179	10,332,420		10,332,420	(9,711,305)	621,115			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,965,618	1,511,456	10,338,072	17,815,146		17,815,146	(10,744,886)	7,070,260			45

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

Meridian Village Care Center

ID# 0045807

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Beauty Shop Incom	\$ (35,615)	40	1
2	Transportation Income	(127)	14	2
3	Miscellaneous Income	(1,331)	21	3
4	Interest on Past Due Accounts	(2,672)	32	4
5	Maintenance Services Income	(8,466)	6	5
6	IL and AL Expenses	(9,675,690)	43	6
7	Senior Fit	(1,383)	11	7
8	Cafeteria Income	(11)	2	8
9	Activity Income	(16)	11	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,725,311)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Meridian Village Care Center# 0045807

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(2)	0	0	0	0	0	0	0	0	0	0	(2)	1
2	Food Purchase	(1,443)	0	0	0	0	0	0	0	0	0	0	(1,443)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	(5,329)	0	0	0	0	0	0	0	0	0	(5,329)	4
5	Heat and Other Utilities	(38,510)	0	0	0	0	0	0	0	0	0	0	(38,510)	5
6	Maintenance	(8,466)	0	0	0	0	0	0	0	0	0	0	(8,466)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(48,421)	(5,329)	0	(53,750)	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	(1,399)	0	0	0	0	0	0	0	0	0	0	(1,399)	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	(127)	0	0	0	0	0	0	0	0	0	0	(127)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,526)	0	0	0	0	0	0	0	0	0	0	(1,526)	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	(109,974)	0	0	0	0	0	0	0	0	0	(109,974)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(519,354)	0	0	0	0	0	0	0	0	0	0	(519,354)	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):*	(176,402)	0	0	0	0	0	0	0	0	0	0	(176,402)	27
28	TOTAL General Administration	(695,756)	(109,974)	0	(805,730)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(745,703)	(115,303)	0	(861,006)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meridian Village Care Center# 0045807

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	20,263	0	0	0	0	0	0	0	0	0	20,263	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,340)	(189,498)	0	0	0	0	0	0	0	0	0	(192,838)	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	(3,340)	(169,235)	0	(172,575)	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	(35,615)	0	0	0	0	0	0	0	0	0	0	(35,615)	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):*	(9,675,690)	0	0	0	0	0	0	0	0	0	0	(9,675,690)	43
44	TOTAL Special Cost Centers	(9,711,305)	0	0	0	0	0	0	0	0	0	0	(9,711,305)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,460,348)	(284,538)	0	(10,744,886)	45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board Listing at PG6-Supp		Lutheran Convalescent Home	Webster, MO	Lutheran Senior Servi	St. Louis, MO	Home Office
		Mason Pointe Care Center	Chesterfield, MO	In Home Services & H	St. Louis, MO	HHH/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
		Lenori Woods	Columbia, MO	Affordable Housing	St. Louis, MO	Housing
		Concordia Village Care Center	Springfield, IL	LSS Endowment 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	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 Fee - Operating	\$ 647,960	Lutheran Senior Services	100.00%	\$ 537,986	\$ (109,974)	1
2	V	30 Management Fee - Capital		Lutheran Senior Services	100.00%	20,263	20,263	2
3	V	32 HO Excess Interest Income		Lutheran Senior Services	100.00%	(189,498)	(189,498)	3
4	V	4 Laundry	62,628	Lutheran Senior Services	100.00%	57,299	(5,329)	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		\$ 710,588			\$ 426,050	\$ * (284,538)	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:

1/1/2017

Ending:

12/31/2017

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:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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	Management - Operating	Direct Cost	24	\$ 15,652,446	\$ 12,551,639	7,619,082	\$ 537,986	1
2	30	Management - Capital	Direct Cost	24	589,535		7,619,082	20,263	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 16,241,981	\$ 12,551,639		\$ 558,249	25

Facility Name & ID Number

Meridian Village Care Center

0045807

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	Name of Lender	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			
	A. Directly Facility Related																	
	Long-Term																	
1	Missouri HEFA						\$	\$				\$						
2	2010 Bonds		X	Campus Expansion	Various	10/31/2010	6,958,280	6,369,893	2/1/2042	Variable		241,917						
3	2007C Bonds		X				2,128,919	1,913,627				122,652						
4	Interest Income											(192,838)						
5	Bond Financing Costs		X									(28,522)						
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$ 9,087,199	\$ 8,283,520				\$ 143,209						
	B. Non-Facility Related*																	
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$ 9,087,199	\$ 8,283,520				\$ 143,209						

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.)

2016 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 2016 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 2016.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>14-1-15-28-00-000-005</u>	<u>PT N 1/2 NE</u>	\$ <u>138,028.04</u>	\$ <u>115,964.00</u>
2.	<u>14-1-15-28-00-000-005.001</u>	<u>PT N 1/2 NE</u>	\$ <u>91,391.44</u>	\$ <u>51,767.00</u>
3.	<u>14-1-15-28-00-000-005.002</u>	<u>PART NORTH 1/2 NORTHEAST</u>	\$ <u>287,359.48</u>	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>516,778.96</u></u>	\$ <u><u>167,731.00</u></u>

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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:

1/1/2017

Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,866 B. General Construction Type: Exterior Brick & Siding Frame Wood Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Meridian Village operates 53 assisted living units, 14 assisted living memory care units, 129 independent living apartments, and 34 patio homes

(Meridian Village Association - Independent Living, 55,240 Square Feet; Meridian Village Association III - Assisted Living, 50,790 Square Feet, and Independent Living, 30,716 Square Feet)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [] YES [] NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and an empty column. Row 1: Senior Living Facility, 2003, \$622,399. Row 2: (blank). Row 3: TOTALS, \$622,399.

Facility Name & ID Number Meridian Village Care Center

0045807

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	70			2010	\$ 6,310,444	\$ 189,505	40	\$ 189,505	\$	\$ 1,358,117	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		2006		26,805	1,434	Various	1,434		21,787	9
10	Various		2007		14,905	994	15	994		10,434	10
11	PANELS,ACOUSTICAL		2008		3,721	248	15	248		2,357	11
12	CONDENSER-DINING AREA		2008		2,118	141	15	141		1,341	12
13	CORNER GUARDS		2008		1,257	84	15	84		797	13
14	PAINTING-501-524		2008		950		7			950	14
15	SOUND SYSTEM		2008		1,763	118	15	118		1,117	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		2,141	17
18	WIRING/ELECTRICAL-OPTIMUS		2010		3,240	216	15	216		1,620	18
19	ACCOUSTICAL SOUND TEST		2010		4,000	267	15	267		2,000	19
20	DOOR W/ KEY PA ENTRY-CC		2010		1,642	109	15	109		821	20
21	A/C&HT, 9,300 BTU		2010		1,176	78	15	78		588	21
22	FLOORING, CARPET		2010		530	76	7	76		568	22
23	DOOR RELEASE, HANDICAP TYPE-VINTAGE GARD		2010		3,052	203	15	203		1,526	23
24	PAINTING-RM TURNAROUNDS		2010		4,000	571	7	571		4,285	24
25	DOOR RELEASE, HANDICAP-COURTYARD ENTRA		2010		448		7			448	25
26	A/C, PTAC ISLANDAIRE,9300 BTU		2010		1,176	78	15	78		588	26
27	A/C, PTAC,ISLANDAIR,9300 BTU		2010		1,176	78	15	78		588	27
28	CABINETS, SPA		2010		1,073	72	15	72		537	28
29	ARCHITECTURAL CONSULTANT		2011		227	15	15	15		106	29
30	SIGNS, INTERIOR		2011		134	9	15	9		62	30
31	ARIAL SYSTEM UPGRADE		2011		4,867	324	15	324		2,217	31
32	DOOR, ACCORDIAN&INSTALLATION		2011		1,007	67	15	67		431	32
33	FLOORING, CARPET-COMMON AREAS,VINATAGE G		2011		16,433	2,348	7	2,348		14,673	33
34	ARCHITECTURAL CONSULTANT		2011		133	9	15	9		62	34
35	SIGNS, INTERIOR		2011		78	5	15	5		36	35
36	A/C, PTAC, 9300 BTU, ISLANDAIR		2012		4,704	314	15	314		1,882	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:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	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-RESIDENT RMS	2012	\$ 22,314	\$ 3,188	7	\$ 3,188	\$	\$ 17,267	37
38	ELECTRICAL UPGRADES-DATA JACK	2012	874	58	15	58		310	38
39	ARCHITECT CONSULTANT	2013	3,900	98	40	98		489	39
40	FLOORING, CARPET-#98026	2013	951	190	5	190		871	40
41	A/C UNITS- VINTAGE GARDENS	2013	1,165	78	15	78		350	41
42	CAT-5 DATA DROP CC & VINTAGE GARDENS (3)	2013	4,367	291	15	291		1,358	42
43	FLOORING - VINYL - ROOM #524	2014	249	50	5	50		183	43
44	FLOORING-CARPET ROOM #512	2014	1,250	250	5	250		833	44
45	FLOORING-CARPET ROOM #628	2014	834	167	5	167		542	45
46	FLOORING-VINYL ROOM #512	2014	1,226	245	5	245		776	46
47	FLOORING-VINYL CAVE CTR	2015	3,399	486	7	486		1,457	47
48	CARPET #27-638	2015	948	190	5	190		553	48
49	CARPET #1-631	2015	957	191	5	191		526	49
50	CARPET #1-633	2015	957	191	5	191		526	50
51	COMMON AREA PLANK FLOORING	2015	941	134	7	134		369	51
52	CARPET #1-627	2015	932	186	5	186		512	52
53	FLOORING-CARPETING 243	2015	1,192	238	5	238		596	53
54	REPLACE CARE CENTER DOORS	2015	9,471	631	15	631		1,578	54
55	REPLACE EXIT DEVICE ON EXIT DOOR	2015	1,565	104	15	104		243	55
56	BLINDS FOR IL, C/C HALL, POOL	2015	2,000	133	15	133		311	56
57	UPGRADE 4 LOCKS WITH KEYPADS	2015	2,812	187	15	187		421	57
58	CABINETS FOR VINT GARDEN	2015	3,547	237	15	237		533	58
59	CABINETS FOR VINT GARDEN	2015	273	18	15	18		41	59
60	VINYL FLOORING UNIT 1-RETREAT	2015	2,309	330	7	330		715	60
61	VINYL FLOORING UNIT 1-MAIN DR.	2015	8,965	1,281	7	1,281		2,775	61
62	GE ZONELINE PTAC	2015	1,274	127	10	127		276	62
63	GE ZONELINE PTAC	2015	1,414	141	10	141		306	63
64	QTY 3 PTAC 12K BTU	2015	1,086	109	10	109		227	64
65	QTY 3 PTAC 12K BTU	2015	1,414	141	10	141		294	65
66	COUNTERTOP, VINTAGE GARDENS	2015	1,362	91	15	91		189	66
67	RM FINISHES FIXTURES, VINTAGE GARDENS	2015	176	12	15	12		25	67
68	RM FINISHES FIXTURES, VINTAGE GARDENS	2015	103	7	15	7		14	68
69	CARPET TO TILE REDUCERS	2016	849	142	5	142		284	69
70	TOTAL (lines 4 thru 69)		\$ 6,502,494	\$ 207,570		\$ 207,570	\$	\$ 1,469,906	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:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,502,494	\$ 207,570		\$ 207,570	\$	\$ 1,469,906	1
2	ceiling fans qty 2	2016	2,554	99	15	99		198	2
3	FRIEDRICH VEA SERIES VTAC QTY 3	2016	5,208	174	15	174		348	3
4	PAGER QTY 10	2016	1,597	44	15	44		88	4
5	CABLE FOR NETWORK E.H.R. PROJECT	2016	340	9	15	9		18	5
6	CABLE DROPS FOR E.H.R. NETWORK PROJ	2016	1,201	33	15	33		66	6
7	CARPET & V PLANK UNIT 437	2016	586	29	5	29		58	7
8	CARPET & V PLANK UNIT 480	2016	1,386	69	5	69		138	8
9	PAGER QTY 6	2016	952	16	15	16		32	9
10	CARPET UNIT 451	2016	2,042	68	5	68		136	10
11	PAGER QTY 6	2016	950	5	15	5		10	11
12	CABINETS & COUNTERTOP	2016	1,323	7	15	7		14	12
13	V PLANK UNIT 501	2016	1,748	29	5	29		58	13
14	V PLANK UNIT 507	2016	2,426	40	5	40		80	14
15	FRIEDRICH VTAC QTY 3	2016	5,208	29	15	29		58	15
16	VINYL PLANK FLOORING	2017	881		5				16
17	VINYL FLOORING UNIT 513	2017	430	7	5	7		7	17
18	VINYL PLANK FLOORING	2017	702	12	5	12		12	18
19	CARPET UNIT 609	2017	1,105	37	5	37		37	19
20	VINYL FLOORING UNIT 517	2017	463	15	5	15		15	20
21	VINYL FLOORING UNIT 510	2017	397	26	5	26		26	21
22	CARPET-CARE CTR COMMON AREA	2017	1,450	69	7	69		69	22
23	FLOORING RM 520	2017	828	69	5	69		69	23
24	PTAC S#AH110279 UNIT 511	2017	692	52	10	52		52	24
25	PTAC S#AH110278 CC RES ROOM 405	2017	692	52	10	52		52	25
26	PTAC S#AH110276 CC RES ROOM 417	2017	692	52	10	52		52	26
27	PTAC S#AH110277 CC RES ROOM	2017	692	52	10	52		52	27
28	PTAC S#AH110177 CC RES ROOM	2017	692	52	10	52		52	28
29	PTAC S#HF367642 CC RES ROOM	2017	692	52	10	52		52	29
30	SECURE CARE WANDERING SYSTEM	2017	11,962	665	15	665		665	30
31	DELL LATITUDE - OPERATIONS	2017	1,254	21	5	21		21	31
32	RECLINER QTY 24 - REACH RES ROOMS	2017	29,900	356	7	356		356	32
33	DELL XPS 13 - LALONHI KAONOH	2017	1,680	28	5	28		28	33
34	TOTAL (lines 1 thru 33)		\$ 6,585,218	\$ 209,837		\$ 209,837	\$	\$ 1,472,824	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:

1/1/2017

Ending:

12/31/2017

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,585,218	\$ 209,837		\$ 209,837	\$	\$ 1,472,824	1
2	DELL LATITUDE 5580-MEDCART VG	2017	1,100	18	5	18		18	2
3	DELL LATITUDE 5580-MEDCART VG	2017	1,100	18	5	18		18	3
4	DELL LATITUDE 5580-MEDCART MAPLE	2017	1,100	18	5	18		18	4
5	DELL LATITUDE 5580-MEDCART REACH	2017	1,100	18	5	18		18	5
6	DELL LATITUDE 5580-MEDCART REACH	2017	1,100	18	5	18		18	6
7	DELL LATITUDE-TRACY JACKSON	2017	1,400	23	5	23		23	7
8	WASHER - CC LAUNDRY	2017	744	12	10	12		12	8
9	ELEC INDUCTION COOKTOP S#SH718133	2017	825	21	10	21		21	9
10	ELEC INDUCTION COOKTOP S#SH706912	2017	825	21	10	21		21	10
11	EHR Billing Software	2017	4,390	157	7	157		157	11
12	EHR Billing Software	2017	2,290	82	7	82		82	12
13	FOAM MATTRESS QTY 4	2017	676	48	7	48		48	13
14	FOLD-UP WHEEL CHAIR SCALE	2017	2,025	145	7	145		145	14
15	UNDCTR D/W - MAPLE LANE	2017	3,832	192	10	192		192	15
16	ENGR PROBE FOR VITAL SIGNS MONITOR	2017	455	43	7	43		43	16
17	ORAL PROBE FOR VITAL SIGNS MONITOR	2017	169	16	7	16		16	17
18	DELL LATITUDE E5570-HR COORD	2017	1,335	178	5	178		178	18
19	LATITUDE E5570-HMGBIRD MED CART	2017	1,100	147	5	147		147	19
20	ICE/WATER DISPENSER - REACH	2017	5,174	388	10	388		388	20
21	DISH MACHINE WATER PUMP	2017	2,301	192	10	192		192	21
22	DELL LATITUDE E5570-SUSAN CARTER	2017	1,220	224	5	224		224	22
23	DMR RADIO QTY 6	2017	1,794	256	7	256		256	23
24									24
25									25
26	HO Depreciation Allocation			20,263		20,263			26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,621,272	\$ 232,336		\$ 232,336	\$	\$ 1,475,060	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:

1/1/2017

Ending:

12/31/2017

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	\$ 1,107,170	\$ 200,308	\$ 200,308	\$	Various	\$ 1,010,820	71
72	Current Year Purchases	68,887	2,640	2,640		Various	2,640	72
73	Fully Depreciated Assets	113,510					113,510	73
74								74
75	TOTALS	\$ 1,289,567	\$ 202,948	\$ 202,948	\$		\$ 1,126,970	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,586,973	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 435,284	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 435,284	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,655,765	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Common Area Renovated - 2006	\$ 3,771	\$ 251	\$ 2,891	86
87	Independent Living	40,647,240	1,512,812	18,424,503	87
88	Assisted Living	696,095	70,580	347,423	88
89	Assisted Living Dementia	550,797	35,200	338,742	89
90					90
91	TOTALS	\$ 41,897,903	\$ 1,618,843	\$ 19,113,559	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

Facility Name & ID Number Meridian Village Care Center

0045807

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

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. _____ /2018 \$ _____

13. _____ /2019 \$ _____

14. _____ /2020 \$ _____

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: \$ 4,617

Description: Nursing, Activities & A&G

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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			
		1	2	3	4
		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	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	\$	5,593	\$ 275,279	\$	5,593	\$ 275,279	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,447	85,402		1,447	85,402	2
3	Licensed Recreational Therapist	V10A-3	hrs							3
4	Licensed Physical Therapist		hrs		6,327	282,578		6,327	282,578	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				301,820		301,820	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Billable Supplies</u>	V-39-2					78,178		78,178	12
13	Other (specify): <u>Other (See WTB)</u>					99,292			99,292	13
14	TOTAL			\$	13,367	\$ 742,551	\$ 379,998	13,367	\$ 1,122,549	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,706,545	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 475,700)	916,888		3
4	Supply Inventory (priced at)	50,814		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	67,859		7
8	Accounts Receivable (owners or related parties)	(3,300)		8
9	Other(specify): Other Current Assets	20,907		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,759,713	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,541,449		13
14	Buildings, at Historical Cost	44,700,511		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,242,916		16
17	Accumulated Depreciation (book methods)	(21,769,324)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 28,715,552	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 31,475,265	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 75,893	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	493,199		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,454		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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 587,546	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,025,535		39
40	Mortgage Payable	35,562,985		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Entrance Fees Payable	10,424,159		43
44	Resident Deposits	324,282		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 47,336,961	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 47,924,507	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (16,449,242)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 31,475,265	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (16,362,045)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (16,362,045)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(87,190)	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	(7)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (87,197)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (16,449,242)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Meridian Village Care Center

0045807

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,104,310	1
2	Discounts and Allowances for all Levels	(2,932,068)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,172,242	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,803,176	6
7	Oxygen	1,572	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,804,748	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	46,096	13
14	Non-Patient Meals	2	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	453,671	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	65,017	19
20	Radiology and X-Ray	23,532	20
21	Other Medical Services	65,592	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 653,910	23
D. Non-Operating Revenue			
24	Contributions	137,483	24
25	Interest and Other Investment Income***	668	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 138,151	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	4,699	28
28a	IL and AL Revenue	9,954,206	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,958,905	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 17,727,956	30

1		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	774,332	31
32	Health Care	3,329,850	32
33	General Administration	2,459,745	33
B. Capital Expense			
34	Ownership	918,799	34
C. Ancillary Expense			
35	Special Cost Centers	10,190,595	35
36	Provider Participation Fee	141,825	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,815,146	40
41	Income before Income Taxes (line 30 minus line 40)**	(87,190)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (87,190)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 310,442	44
45	Private Pay - Net Inpatient Revenue	3,875,355	45
46	Medicare - Net Inpatient Revenue	689,371	46
47	Other-(specify) Benevolent Care	(145,188)	47
48	Other-(specify) Managed Care	442,262	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,172,242	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:

1/1/2017

Ending:

12/31/2017

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	1,888	2,000	\$ 86,740	\$ 43.37	1
2	Assistant Director of Nursing	2,856	3,145	95,932	30.50	2
3	Registered Nurses	5,716	6,703	229,661	34.26	3
4	Licensed Practical Nurses	27,709	30,128	791,781	26.28	4
5	CNAs & Orderlies	66,672	75,834	1,090,244	14.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,930	8,469	153,156	18.08	10
11	Social Service Workers	3,219	3,243	60,422	18.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,636	8,189	106,986	13.06	15
16	Dishwashers					16
17	Maintenance Workers	3,508	3,762	79,071	21.02	17
18	Housekeepers	3,499	3,771	45,458	12.05	18
19	Laundry					19
20	Administrator	1,957	2,080	85,572	41.14	20
21	Assistant Administrator					21
22	Other Administrative	13,207	17,927	232,289	12.96	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	1,488	1,495	24,553	16.42	31
32	Other Health C: <u>Marketing</u>			49		32
33	Other(specify) <u>AL/IL</u>	166,532	181,418	2,883,704	15.90	33
34	TOTAL (lines 1 - 33)	313,817	348,164	\$ 5,965,618 *	\$ 17.13	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	\$		35	
36	Medical Director	Monthly 30,000	V9-3	36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	88	6,976	V39-3	39
40	Physical Therapy Consultant			V10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	384	17,411	V39-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	298	V11-3	44
45	Social Service Consultant	46	3,082	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	528	\$ 57,767		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Drew Redman	Administrator		\$ 85,572	Workers' Compensation Insurance	\$ 60,308	IDPH License Fee	\$	
				Unemployment Compensation Insurance	7,738	Advertising: Employee Recruitment	26	
				FICA Taxes	234,551	Health Care Worker Background Check (Indicate # of checks performed 833)	5,204	
				Employee Health Insurance	322,244	Patient Background Checks	433 5,029	
				Employee Meals		Subscriptions	2,398	
				Illinois Municipal Retirement Fund (IMRF)*		Leading Age	11,271	
				Disability Insurance	6,375	Other Dues & Memberships	695	
				Life Insurance	3,821	Licenses	1,239	
				Savings & Revenue Sharing	18,095			
				Dental Insurance	18,640	Less: Public Relations Expense	()	
				Tuition Reimbursement	276	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 85,572	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 672,048		\$ 25,862		
B. Administrative - Other			E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	4,711
							Seminar Expense	9,477
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 14,188	
C. Professional Services								
Vendor/Payee	Type		Amount					
Lutheran Senior Services	Management Services		\$ 647,960					
CliftonLarsonAllen LLP	Audit/Tax/Cost Report		6,268					
Polsinelli PC	Legal Services		(6,014)					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 648,214	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Meridian Village Care Center

0045807

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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 \$11,271
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,073 Line 39
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 141,825
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. \$ 2
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees