		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0051078

Facility Name: Concordia Village Care Ctr

Address: 4101 West Iles Ave (Number) Springfield (City) 62711 (Zip Code)

County: Sangamon

Telephone Number: (217) 793-9429 **Fax #** (217) 793-1333

HFS ID Number:

Date of Initial License for Current Owners: 5/1/2012

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(c)3		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact
Name: Kevin Wellen, CPA **Telephone Number:** (314) 925-4446
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Chad Sneed
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Kevin Wellen, CPA, Signing Director
(Firm Name & Address) CliftonLarsonAllen, LLP, 600 Washington Ave. Ste. 1800, St. Louis, MO 63101
(Telephone) (314) 925-4446 Fax # (314) 925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 **Phone # (217) 782-1630**

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	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	62	TOTALS	62	22,630	7

B. Census-For the entire report period.

	Level of Care	1 Medicaid Fee for Service	2 Medicaid MLTSS	3 MMAI Medicaid Primary	4 MMAI Medicare Primary	5 Private Pay	6 Medicare Part A Only	7 Other	8 Total	
		Patient Days by Level of Care and Primary Source of Payment								
8	SNF	718				14,136	1,909	1,806	18,569	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	718				14,136	1,909	1,806	18,569	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 82.05%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

I. On what date did you start providing long term care at this location?
Date started 5/1/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/1/2012 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 62

Medicare Intermediary Wellpoint Federal (NGS)

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 **Report Period Beginning:** 1/1/2025 **Ending:** 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	2,158,143	143,827	37,853	2,339,823		2,339,823	(1,654,192)	685,631			1
2	Food Purchase		952,262		952,262		952,262	(686,296)	265,966			2
3	Housekeeping	582,811	89,920	21,000	693,731		693,731	(506,582)	187,149			3
4	Laundry	41,610	16,405	65,253	123,268		123,268		123,268			4
5	Heat and Other Utilities			1,291,152	1,291,152		1,291,152	(1,218,332)	72,820			5
6	Maintenance	808,108	131,621	716,902	1,656,631		1,656,631	(1,521,665)	134,966			6
7	Other (specify):*											7
8	**TOTAL General Services**	3,590,672	1,334,035	2,132,160	7,056,867		7,056,867	(5,587,067)	1,469,800			8
	B. Health Care and Programs											
9	Medical Director			32,100	32,100		32,100		32,100			9
10	Nursing and Medical Records	3,130,634	93,665	7,195	3,231,494		3,231,494		3,231,494			10
10a	Therapy			658,375	658,375		658,375		658,375			10a
11	Activities	444,750	8,555	18,424	471,729		471,729	(250,472)	221,257			11
12	Social Services	46,459			46,459		46,459		46,459			12
13	CNA Training											13
14	Program Transportation	101,330	10,181	5,525	117,036		117,036	(100,517)	16,519			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,723,173	112,401	721,619	4,557,193		4,557,193	(350,989)	4,206,204			16
	C. General Administration											
17	Administrative	138,281		592,984	731,265		731,265	(11,538)	719,727			17
18	Directors Fees											18
19	Professional Services			318,320	318,320		318,320	(246,644)	71,676			19
20	Dues, Fees, Subscriptions & Promotions			78,672	78,672	66,872	145,544	(39,941)	105,603			20
21	Clerical & General Office Expenses	542,351	59,700	534,097	1,136,148	(63,499)	1,072,649	(864,433)	208,216			21
22	Employee Benefits & Payroll Taxes			629,987	629,987		629,987		629,987			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,978	10,978		10,978	(7,675)	3,303			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			135,236	135,236		135,236		135,236			26
27	Other (specify):* Marketing	273,773	35,146	45,779	354,698		354,698	(354,698)				27
28	**TOTAL General Administration**	954,405	94,846	2,346,053	3,395,304	3,373	3,398,677	(1,524,929)	1,873,748			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,268,250	1,541,282	5,199,832	15,009,364	3,373	15,012,737	(7,462,985)	7,549,752			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 Concordia Village Care Ctr #0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR BHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			552,847	552,847		552,847	12,240	565,087			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			403,405	403,405		403,405	(293,406)	109,999			32
33	Real Estate Taxes			58,266	58,266		58,266		58,266			33
34	Rent-Facility & Grounds			7,650	7,650		7,650		7,650			34
35	Rent-Equipment & Vehicles							(6,089)	(6,089)			35
36	Other (specify):*											36
37	TOTAL Ownership			1,022,168	1,022,168		1,022,168	(287,255)	734,913			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		220,598	20,314	240,912		240,912		240,912			39
40	Barber and Beauty Shops			13,493	13,493		13,493	(13,493)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			190,333	190,333		190,333		190,333			42
43	Other (specify):* AL/IL	2,049,254	49,028	8,155,977	10,254,259	(3,373)	10,250,886	(10,254,259)	(3,373)			43
44	TOTAL Special Cost Centers	2,049,254	269,626	8,380,117	10,698,997	(3,373)	10,695,624	(10,267,752)	427,872			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,317,504	1,810,908	14,602,117	26,730,529		26,730,529	(18,017,992)	8,712,537			45

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(31,355)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(14,790)	32		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	(9,678)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(72,807)	21		24
25	Fund Raising, Advertising and Promotional	(354,698)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (483,328)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(277,718)		34
35	Other- Attach Schedule	(17,256,946)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (17,534,664)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (18,017,992)		37

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

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

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

Concordia Village Care Ctr

ID# 0051078

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Barber & Beauty Income (limited to expense)	(13,493)	40	3
4	Transportation Income	(2,715)	14	4
5	Interest on Past Due Accounts	(196)	32	5
6	Maintenance Services Income	634	6	6
7	AL and IL Direct Expenses	(10,254,259)	43	7
8	Liquor	(8,564)	2	8
9	Gift Shoppe Supplies	0	1	9
10	IT Services Income	0	21	10
11	Telephone Income	(636)	21	11
12	Non-Patient Meals	(362)	1	12
13	Non-SNF Dietary Costs	(1,653,830)	1	13
14	Non-SNF Food Purchases	(677,732)	2	14
15	Non-SNF Housekeeping	(506,582)	3	15
16	Non-SNF Utilities	(1,186,977)	5	16
17	Non-SNF Maintenance	(1,522,299)	6	17
18	Non-SNF Activities	(250,472)	11	18
19	Non-SNF Transportation	(97,802)	14	19
20	Non-SNF Professional Fees	(246,644)	19	20
21	Non-SNF Dues, Fees, Subscriptions, & Promotions	(39,941)	20	21
22	Non-SNF Clerical & Office Expense	(781,312)	21	22
23	Non-SNF Travel & Seminar	(7,675)	24	23
24	Non-SNF Equipment Rental	(6,089)	35	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**	(17,256,946)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,654,192)	0	0	0	0	0	0	0	0	0	0	(1,654,192)	1
2	Food Purchase	(686,296)	0	0	0	0	0	0	0	0	0	0	(686,296)	2
3	Housekeeping	(506,582)	0	0	0	0	0	0	0	0	0	0	(506,582)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,218,332)	0	0	0	0	0	0	0	0	0	0	(1,218,332)	5
6	Maintenance	(1,521,665)	0	0	0	0	0	0	0	0	0	0	(1,521,665)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,587,067)	0	0	0	0	0	0	0	0	0	0	(5,587,067)	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	(250,472)	0	0	0	0	0	0	0	0	0	0	(250,472)	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	(100,517)	0	0	0	0	0	0	0	0	0	0	(100,517)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	(350,989)	0	0	0	0	0	0	0	0	0	0	(350,989)	16
	C. General Administration													
17	Administrative	0	(11,538)	0	0	0	0	0	0	0	0	0	(11,538)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(246,644)	0	0	0	0	0	0	0	0	0	0	(246,644)	19
20	Fees, Subscriptions & Promotions	(39,941)	0	0	0	0	0	0	0	0	0	0	(39,941)	20
21	Clerical & General Office Expenses	(864,433)	0	0	0	0	0	0	0	0	0	0	(864,433)	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	(7,675)	0	0	0	0	0	0	0	0	0	0	(7,675)	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):*	(354,698)	0	0	0	0	0	0	0	0	0	0	(354,698)	27
28	**TOTAL General Administration**	(1,513,391)	(11,538)	0	0	0	0	0	0	0	0	0	(1,524,929)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,451,447)	(11,538)	0	0	0	0	0	0	0	0	0	(7,462,985)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concordia Village Care Ctr # 0051078 **Report Period Beginning:** 1/1/2025 **Ending:** 12/31/2025

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	12,240	0	0	0	0	0	0	0	0	0	12,240	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,986)	(278,420)	0	0	0	0	0	0	0	0	0	(293,406)	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	(6,089)	0	0	0	0	0	0	0	0	0	0	(6,089)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(21,075)	(266,180)	0	0	0	0	0	0	0	0	0	(287,255)	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	(13,493)	0	0	0	0	0	0	0	0	0	0	(13,493)	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):*	(10,254,259)	0	0	0	0	0	0	0	0	0	0	(10,254,259)	43
44	**TOTAL Special Cost Centers**	(10,267,752)	0	0	0	0	0	0	0	0	0	0	(10,267,752)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(17,740,274)	(277,718)	0	0	0	0	0	0	0	0	0	(18,017,992)	45

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 Ownership-1		See full listing at PG6-Supp		See full listing at PG6-Supp		

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

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

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Management Fee	$ 592,984	Lutheran Senior Services	100.00%	$ 581,446	$ (11,538)	1
2	V		30	Management Fee		Lutheran Senior Services	100.00%	12,240	12,240	2
3	V		32	HO Excess Interest Income		Lutheran Senior Services	100.00%	(278,420)	(278,420)	3
4	V		1	Dietician	36,972	Lutheran Senior Services	100.00%	36,972		4
5	V		10	Medical Records	15,165	Lutheran Senior Services	100.00%	15,165		5
6	V		21	HR Recruitment	151,365	Lutheran Senior Services	100.00%	151,365		6
7	V		43	Medical Records	9,748	Lutheran Senior Services	100.00%	9,748		7
8	V		21	IT Services						8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 806,234			$ 528,516	$ * (277,718)	14

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

STATE OF ILLINOIS **Ownership Listing-1**

Concordia Village Care Ctr

ID# **0051078**

Report Period Beginning: **1/1/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	David		Anderson	St. Louis	MO				1
2	Rev. Christopher		Sommer	St. Louis	MO				2
3	Dan		Brown	St. Louis	MO				3
4	Brent		Beumer	St. Louis	MO				4
5	Rev. Roy		Christell	St. Louis	MO				5
6	Lauren		Colling	St. Louis	MO				6
7	Adam		Marles	St. Louis	MO				7
8	Megan		Meadows	St. Louis	MO				8
9	Harry		Mueller	St. Louis	MO				9
10	Deborah		Schroeder-Saulinier	St. Louis	MO				10
11	Lisa		Sombart	St. Louis	MO				11
12	Paul		Tice	St. Louis	MO				12
13	Norman		Toon	St. Louis	MO				13
14	Dr. Justin		Hugo	St. Louis	MO				14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
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71									71
72									72
73									73
74									74
75									75

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Lutheran Convalescent Home	St. Louis, MO			In Home Services and	St. Louis, MO	Hospice	1
2	LSS - Mason Pointe	Town and County, MO			Laclede Groves	St. Louis, MO	AL/IL	2
3	LSS - Breeze Park	Weldon Springs, MO			Mason Pointe	Toun and County, MO	AL/IL	3
4	LSS - Lenoir Woods	Columbia, MO			Breeze Park	Weldon Springs, MO	AL/IL	4
5	LSS - Meridian Village	Glen Carbon, IL			Lenoir Woods	Columbia, MO	AL/IL	5
6	LSS - Meramec Bluffs	Ballwin, MO			Meridian Village	Glen Carbon, IL	AL/IL	6
7	Lutheran Hillside Village	Peoria, IL			Meramec Bluffs	Ballwin, MO	AL/IL	7
8	Buffalo Valley Lutheran Village	Lewisburg, PA			Provident Group	St. Louis, MO	Development Co.	8
9	Cumberland Crossings Retirement	Carlisle, PA			Richmond Terrace	Richmond Heights, MO	AL	9
10	Luther Crest Nursing Facility	Allentown, PA			Concordia Village	Springfield, IL	AL/IL	10
11	The Lutheran Home of Topton	Topton, PA			202 HUD Projects	St. Louis, MO	Affordable Housing	11
12	LSS - Brooking Park	St. Louis, MO			LSS Endowment Fund	St. Louis, MO	Foundation	12
13					Lutheran Hillside Vill	Peoria, IL	AL/IL	13
14					Lutheran Senior Servi	St. Louis, MO	Home Office	14
15					St. Louis Home Health	St. Louis, MO	Home Health	15
16					Prime Acquisitions LL	St. Louis, MO	PACE	16
17					Prime Acquisitions LL	St. Louis, MO	PACE	17
18					Diakon Lutheran Soci	Middleton, PA	Regional Home Offi	18
19					Buffalo Valley	Lewisburg, PA	AL/IL	19
20					Cumberland Crossing	Carlisle, PA	AL/IL	20
21					Luther Crest	Allentown, PA	AL/IL	21
22					Lutheran Home of To	Topton, PA	AL/IL	22
23					LSS East Foundation	Middleton, PA	Foundation	23
24					Brooking Park Crossi	St. Louis, MO	AL/IL	24
25					Cape Albeon	St. Louis, MO	AL/IL	25
26					Tower Grove Manor	St. Louis, MO	AL/IL	26
27					STAMS	St. Louis, MO	Management Comp	27
28					STACF	St. Louis, MO	Foundation	28
29					STARS HUD Projects	St. Louis, MO	Affordable Housing	29
30					Senior Solutions Cross	St. Louis, MO	Home Care/Private	30

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management - Operating	Direct Cost	436,753,747	34	$ 26,650,439	$ 17,013,455	9,528,950	$ 581,451	1
2	30	Management - Capital	Direct Cost	436,753,747	34	560,999		9,528,950	12,240	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
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 27,211,438	$ 17,013,455		$ 593,691	25

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Deferred Financing Costs						$	$			$ (42,672)	1
2	2019C Bonds		X	Campus Expansion		10/13/2010	12,369,734	9,384,073	2042	Various	446,077	2
3	Interest Income										(14,790)	3
4	HO Excess Interest Income										(278,420)	4
5	Interest on Past Due Accts										(196)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 12,369,734	$ 9,384,073			$ 109,999	9
	B. Non-Facility Related*											
10	Bonds - IL/AL							37,827,448				10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 37,827,448			$	14
15	TOTALS (line 9+line14)						$ 12,369,734	$ 47,211,521			$ 109,999	15

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

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

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	58,266	2
3. Under or (over) accrual (line 2 minus line 1).	$	58,266	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	58,266	7

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020	33,741	9
	2021	35,531	10
	2022	54,682	11
	2023	58,115	12
	2024	58,266	13

FOR BHF USE ONLY

14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concordia Village Care Ctr COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0051078

CONTACT PERSON REGARDING THIS REPORT Chad Sneed

TELEPHONE (314) 446-2405 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-02.0-451-001	Land 17.31 Acres	$ 344,277.66	$ 58,266.00
2.	21-02.0-400-029	Land 6.95 Acres	$ 39,704.94	$
3.	21-02.0-400-066	Land 4.62 Acres	$ 7,573.12	$
4.	21-02.0-400-075	Land 3.92 Acres	$ 6,421.48	$
5.	21-02.0-400-070	Land 4.67 Acres	$ 7,654.88	$
6.	Various - see RE Tax Bills	Land (various)	$ 148,724.53	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 554,356.61	$ 58,266.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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 Numb Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. **Square Feet:** 39,026 **B. General Construction Type:** **Exterior** Masonry **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 ground (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)**

Concordia Village operates 48 assisted living units, 178 independent living apartments, and 26 patio home

F. List the bed capacity for the building if it differs from the licensed total. N/A

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? No

J. 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.

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

If so, please complete the following:

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

3. Current Period Amortization: **4. Dates Incurred:**

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Care Center	120,000	2010	$ 77,462	1
2					2
3	TOTALS	120,000		$ 77,462	3

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	62			2011	$ 8,820,369	$ 276,733	Various	$ 276,733	$	$ 3,862,752	4
5				2020	2,331,796	85,524	Various	85,524		520,270	5
6											6
7											7
8											8
	Improvement Type**										
9	2012 Improvements			2012	6,265	418	Various	418		5,707	9
10	2016 Improvements			2016	58,904	429	Various	429		56,601	10
11	2017 Improvements			2017	62,020		7			62,020	11
12	2018 Improvements			2018	7,999	533	15	533		3,999	12
13	2019 Improvements			2019	390,577	36,412	Various	36,412		248,300	13
14	2020 Improvements			2020	4,321	360	15	360		2,011	14
15											15
16	HEAT PUMP REPLACE #8			2021	5,040	336	15	336		1,512	16
17	PTAC/PTHP/VTAC			2021	737	49	15	49		217	17
18	PTAC/PTHP/VTAC			2021	4,421	442	10	442		1,879	18
19	AMANAptac 2111001142,44,45,46,47,51			2022	5,143	343	15	343		1,372	19
20	REACH 3TON DUCANE HEATPUMP			2022	7,830	522	15	522		1,697	20
21	STOCK AMANA PTACS			2022	1,836	122	15	122		377	21
22	Laundry room lenel - progress billing			2023	2,231	149	15	149		384	22
23	Laundry room lenel - progress billing			2023	3,530	235	15	235		588	23
24	Door security system - staff hal			2023	5,700	380	15	380		918	24
25											25
26	Home Office Depreciation Allocation					12,240		12,240			26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											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 Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	$ 350,886	$ 136,207	$ 136,207	$	Various	$ 281,404	71
72	Current Year Purchases	3,345	199	199			199	72
73	Fully Depreciated Assets	625,179	13,454	13,454		Various	624,732	73
74								74
75	TOTALS	$ 979,410	$ 149,860	$ 149,860	$		$ 906,335	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	Facility - SNF	VAN-W/C 2013 FORD E250 5+2	2013	$ 42,355	$	$	$	7	$ 42,355	76
77										77
78										78
79										79
80	TOTALS			$ 42,355	$	$	$		$ 42,355	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)	$ 12,817,946	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 565,087	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 565,087	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)	$ 5,719,294	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	SNF - Laundry	$ 1,696,463	$ 51,447	$ 720,261	86
87	SNF - Site Improvements - 2009	527,860	26,393	435,484	87
88	SNF - Building Improvements 2009	511,084	8,208	318,205	88
89	Independent Living	70,359,277	2,440,205	31,376,951	89
90	AL & AL Memory Care	11,832,830	392,024	6,191,800	90
91	TOTALS	$ 84,927,514	$ 2,918,277	$ 39,042,701	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - IL Renovation	$ 56,000	92
93	CIP - Village Unit Renovation		93
94	Fixed Asset Clearing Acct	222,630	94
95		$ 278,630	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 Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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? ☐ 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	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.	/2026	$
13.	/2027	$
14.	/2028	$

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 ☒ X NO

16. Rental Amount for movable equipment: $ 7,650 Description: EcoLab, Misc. Equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A-3	hrs	$	3,746	$ 239,801	$	3,746	$ 239,801	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		1,512	75,904		1,512	75,904	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		5,791	342,670		5,791	342,670	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				136,064		136,064	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Billable Supplies	V39-2					84,534		84,534	12
13	Other (specify): Lab, Xray, Hospital, R	V39-3,V10-3				20,314			20,314	13
14	TOTAL			$	11,049	$ 678,689	$ 220,598	11,049	$ 899,287	14

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2025 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 27,987,245	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 147,485)	398,630		3
4	Supply Inventory (priced at)	57,711		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,294		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	225,025		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 28,677,905	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,126,732		13
14	Buildings, at Historical Cost	89,648,171		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	7,048,019		16
17	Accumulated Depreciation (book methods)	(44,761,995)		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): CIP	278,630		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 53,339,557	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 82,017,462	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 408,396	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	695,779		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,734		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current Portion of Long-Term Debt	1,007,637		36
37	Other Current Liabilities	3,424,286		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,560,832	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to Related Party	47,202,367		43
44	Other Liabilities	45,122,963		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 92,325,330	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 97,886,162	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (15,868,700)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 82,017,462	$	48

***(See instructions.)**

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (16,514,619)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (16,514,619)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	645,953	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) **Statistical accounts do not net to zero**	(34)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 645,919	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (15,868,700)	24 *

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,048,681	1
2	Discounts and Allowances for all Levels	(658,662)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,390,019	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,444,622	6
7	Oxygen	854	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,445,476	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	18,981	13
14	Non-Patient Meals	362	14
15	Telephone, Television and Radio	636	15
16	Rental of Facility Space		16
17	Sale of Drugs	165,108	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,463	19
20	Radiology and X-Ray	4,647	20
21	Other Medical Services	79,884	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 285,081	23
	D. Non-Operating Revenue		
24	Contributions	190,306	24
25	Interest and Other Investment Income***	14,790	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 205,096	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Revenue	2,277	28
28a	AL/IL Revenue	18,048,533	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,050,810	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 27,376,482	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	7,056,867	31
32	Health Care	4,557,193	32
33	General Administration	3,395,304	33
	B. Capital Expense		
34	Ownership	1,022,168	34
	C. Ancillary Expense		
35	Special Cost Centers	10,508,664	35
36	Provider Participation Fee	190,333	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 26,730,529	40
41	**Income before Income Taxes (line 30 minus line 40)*†**	645,953	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 645,953	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 250,406.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	6,120,705.00	48
49	Medicare Part A	390,272.00	49
50	Other-(specify) Managed Care	628,636.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,390,019	56

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	7,280	7,312	$ 429,717	$ 58.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,874	13,953	706,729	50.65	3
4	Licensed Practical Nurses	11,462	13,726	528,359	38.49	4
5	CNAs & Orderlies	58,048	60,931	1,420,382	23.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,564	14,699	444,750	30.26	10
11	Social Service Workers	947	954	46,459	48.70	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	96,449	97,164	2,158,143	22.21	15
16	Dishwashers					16
17	Maintenance Workers	25,692	25,824	808,108	31.29	17
18	Housekeepers	27,659	27,907	582,811	20.88	18
19	Laundry	1,987	1,997	41,610	20.84	19
20	Administrator	2,080	2,080	138,281	66.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,645	14,189	542,351	38.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,646	1,749	45,447	25.98	31
32	Other Health Cz Transportation	3,726	3,760	101,330	26.95	32
33	Other(specify) AL/IL/Marketing	79,225	82,325	2,323,027	28.22	33
34	TOTAL (lines 1 - 33)	356,284	368,570	$ 10,317,504 *	$ 27.99	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	71	32,100	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,593	V10-3	39
40	Physical Therapy Consultant	Monthly	232	V10A3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	71	$ 38,925		49

C. CONTRACT NURSES

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

Facility Name & ID Number Concordia Village Care Ctr # 0051078 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Rhodes	Administrator	0	$ 138,281
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 138,281

B. Administrative - Other

Description	Amount
Lutheran Senior Services - Management Fee	$ 592,984
TOTAL (agree to Schedule V, line 17, col. 3)	$ 592,984
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Husch Blackwell	Legal	$ 12,220
CliftonLarsonAllen LLP	CR/Audit/Tax	6,809
Workday	Data Processing	49,359
Microsoft Corporation	Data Processing	31,749
Uniguest	Data Processing	28,368
SHI International	Data Processing	18,197
Sirius	Data Processing	16,946
Kronos	Data Processing	13,247
Relias	Data Processing	11,626
Palo Alto	Data Processing	10,647
Aline	Data Processing	7,689
Various	Data Processing	111,463
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 318,320

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 61,314
Unemployment Compensation Insurance	10,542
FICA Taxes	268,462
Employee Health Insurance	233,375
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	7,572
Life Insurance	4,952
Savings & Revenue Sharing	37,767
Dental Insurance	6,003
TOTAL (agree to Schedule V, line 22, col.8)	$ 629,987

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 7,890
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 2213)	61,349
Patient Background Checks 215	2,150
Association Dues (total from pg 22, #4)	23,500
Subscriptions	1,701
Licenses	8,884
Other Dues	129
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 105,603

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,345
Seminar Expense	1,958
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,303

**See instructions.

Facility Name & ID Number Concordia Village Care Ctr **#** 0051078 **Report Period Beginning:** 1/1/2025 **Ending:** 12/31/2025

XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below
Use the drop down list to identify the association.

Association Name	Amount
LEADING AGE	23,500
	23,500 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1

LEADING AGE	
	Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

LEADING AGE	23,500
	23,500 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expens
and the location of this expense on Sch. V. $ 32,046 Line V39-2

(6) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? Yes If NO, attach a complete explanation.

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. $ 190,333
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) Have costs for all supplies and services which are of the type that can be billed t
the Department, in addition to the daily rate, been properly classifie
in the Ancillary Section of Schedule V? Yes

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ Has any meal income been offset agains
related costs? No Indicate the amount. $ N/A

(12) 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 othe
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

(13) Has an audit been performed by an independent certified public accounting firm Yes
Firm Name: CliftonLarsonAllen LLP

(14) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? Yes

(15) 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