

		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: <u>0057919</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Meridian Village Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2025</u> to <u>12/31/2025</u> 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.																									
Address: <u>27 Auerback Place</u> <u>Glen Carbon</u> <u>62034</u> Number City Zip Code																											
County: <u>Madison</u>																											
Telephone Number: <u>(314) 968-9313</u> Fax # <u>(314) 968-5590</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>12/19/2005</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Chad Sneed</u> (Title) <u>Chief Financial Officer</u>																									
Type of Ownership:																											
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(c)3</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other</td><td>_____</td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501(c)3</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Kevin Wellen, CPA</u> <u>Signing Director</u> (Firm Name & Address) <u>CliftonLarsonAllen, LLP</u> <u>600 Washington Ave. Ste. 1800, St. Louis, MO 63101</u> (Telephone) <u>(314) 925-4300</u> Fax # <u>(314) 925-4350</u> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																									
☒ Charitable Corp.	☐ Individual	☐ State																									
☐ Trust	☐ Partnership	☐ County																									
IRS Exemption Code <u>501(c)3</u>	☐ Corporation	☐ Other _____																									
	☐ "Sub-S" Corp.	_____																									
	☐ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other	_____																									
In the event there are further questions about this report, please contact Name: <u>Kevin Wellen, CPA</u> Telephone Number: <u>(314) 925-4300</u> Email Address: _____																											

STATE OF ILLINOIS

Page 2

Facility Name & ID NumberMeridian Village Care Center# 0057919Report Period Beginning: 1/1/2025Ending: 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	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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	2,004				13,760	5,039	1,859	22,662	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,004				13,760	5,039	1,859	22,662	14

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

88.70%

D. How many bed reserve days during this year were paid by the Department?

0 (Do not include bed reserve days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES X NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES X NO

I. On what date did you start providing long term care at this location?

Date started 12/19/2005

J. Was the facility purchased or leased after January 1, 1978?

YES X Date 3/30/2005 NO

K. Was the facility certified for Medicare during the reporting year?

YES X NO If YES, enter certified beds.

number of certified beds 70

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.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	1,776,797	162,866	49,390	1,989,053		1,989,053	(1,354,575)	634,478		1
2	Food Purchase		1,061,177		1,061,177		1,061,177	(744,753)	316,424		2
3	Housekeeping	486,245	48,593	10,206	545,044		545,044	(377,751)	167,293		3
4	Laundry		4,555	61,941	66,496		66,496		66,496		4
5	Heat and Other Utilities			892,759	892,759		892,759	(795,973)	96,786		5
6	Maintenance	597,817	146,072	491,601	1,235,490		1,235,490	(1,067,365)	168,125		6
7	Other (specify):*										7
8	TOTAL General Services	2,860,859	1,423,263	1,505,897	5,790,019		5,790,019	(4,340,417)	1,449,602		8
	B. Health Care and Programs										
9	Medical Director			32,600	32,600		32,600		32,600		9
10	Nursing and Medical Records	3,819,194	59,240	21,109	3,899,543		3,899,543		3,899,543		10
10a	Therapy			1,033,042	1,033,042		1,033,042		1,033,042		10a
11	Activities	604,389	37,003	57,168	698,560		698,560	(555,839)	142,721		11
12	Social Services	74,847		1,431	76,278		76,278		76,278		12
13	CNA Training										13
14	Program Transportation	80,711	9,102	17,042	106,855		106,855	(85,463)	21,392		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,579,141	105,345	1,162,392	5,846,878		5,846,878	(641,302)	5,205,576		16
	C. General Administration										
17	Administrative	156,028		684,857	840,885		840,885	(20,618)	820,267		17
18	Directors Fees										18
19	Professional Services			285,886	285,886		285,886	(210,875)	75,011		19
20	Dues, Fees, Subscriptions & Promotions			90,633	90,633	30,183	120,816	(46,340)	74,476		20
21	Clerical & General Office Expenses	771,020	28,275	383,688	1,182,983	(30,183)	1,152,800	(820,667)	332,133		21
22	Employee Benefits & Payroll Taxes			791,709	791,709		791,709		791,709		22
23	Inservice Training & Education										23
24	Travel and Seminar			10,725	10,725		10,725	(7,577)	3,148		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			154,192	154,192		154,192		154,192		26
27	Other (specify):* Marketing	196,662	10,299	52,779	259,740		259,740	(259,740)			27
28	TOTAL General Administration	1,123,710	38,574	2,454,469	3,616,753		3,616,753	(1,365,817)	2,250,936		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,563,710	1,567,182	5,122,758	15,253,650		15,253,650	(6,347,536)	8,906,114		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	1	2	3	4	5	6	7	8			
30	D. Ownership										30
	Depreciation			382,997	382,997		382,997	13,982	396,979		
31	Amortization of Pre-Op. & Org.										31
32	Interest			319,932	319,932		319,932	(227,815)	92,117		32
33	Real Estate Taxes			108,428	108,428		108,428		108,428		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			811,357	811,357		811,357	(213,833)	597,524		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		391,440	43,420	434,860		434,860		434,860		39
40	Barber and Beauty Shops			13,656	13,656		13,656	(13,656)			40
41	Coffee and Gift Shops		3,183		3,183		3,183		3,183		41
42	Provider Participation Fee			192,037	192,037		192,037		192,037		42
43	Other (specify):* AL/IL	2,114,394	36,118	6,878,040	9,028,552		9,028,552	(9,028,552)			43
44	TOTAL Special Cost Centers	2,114,394	430,741	7,127,153	9,672,288		9,672,288	(9,042,208)	630,080		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	10,678,104	1,997,923	13,061,268	25,737,295		25,737,295	(15,603,577)	10,133,718		45

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,106)	2		4
5	Telephone, TV & Radio in Resident Rooms	(25,655)	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	(8,218)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(58,091)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,334)	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	(33,328)	21		24
25	Fund Raising, Advertising and Promotional	(259,740)	27		25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (392,472)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(227,445)		34
35	Other- Attach Schedule	(14,983,660)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,211,105)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (15,603,577)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#

0057919

1/1/2025

12/31/2025

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Barber & Beauty Income (limited to expense)	(13,656)	40	3
4	Transportation Income	(443)	14	4
5	Interest on Past Due Accounts	1,212	32	5
6	Maintenance Services Income	(1,322)	6	6
7	IL and IL Direct Expenses	(9,028,552)	43	7
8	Guest Room Income		21	8
9	Activities	(25)	11	9
10	Telephone Revenue	(663)	21	10
11	Non-SNF Dietary Costs	(1,354,575)	1	11
12	Non-SNF Food Purchases	(735,872)	2	12
13	Non-SNF Housekeeping	(377,751)	3	13
14	Non-SNF Utilities	(770,318)	5	14
15	Non-SNF Maintenance	(1,066,043)	6	15
16	Non-SNF Activities	(555,814)	11	16
17	Non-SNF Social Services		12	17
18	Non-SNF Transportation	(85,020)	14	18
19	Non-SNF Professional Fees	(210,875)	19	19
20	Non-SNF Dues, Fees, Subscriptions, & Promotions	(46,340)	20	20
21	Non-SNF Clerical & Office Expense	(725,251)	21	21
22	Non-SNF Travel & Seminar	(7,577)	24	22
23	Liquor	(4,775)	2	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	(14,983,660)		49

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		See Board Listing at PG6-Supp		See Board 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.

☒ 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	17	Management Fee - Operating	\$ 684,857	Lutheran Senior Services	100.00%	\$ 664,239	\$ (20,618)	1
2	V	30	Management Fee - Capital		Lutheran Senior Services	100.00%	13,982	13,982	2
3	V	32	HO Excess Interest Income		Lutheran Senior Services	100.00%	(220,809)	(220,809)	3
4	V	21	Recruitment	58,988	Lutheran Senior Services	100.00%	58,988		4
5	V	1	Dietician	45,194	Lutheran Senior Services	100.00%	45,194		5
6	V	10	Medical Records	18,491	Lutheran Senior Services	100.00%	18,491		6
7	V	43	Information Technology		Lutheran Senior Services	100.00%			7
8	V	43	Medical Records	13,976	Lutheran Senior Services	100.00%	13,976		8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 821,506			\$ 594,061	\$ * (227,445)	14

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

Report Period Beginning:

Ending:

ID#

0057919

1/1/2025

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.

			Place of Residence		Operator/Licensee	Building Co.	Management	
	First Name	M.I.	Last Name	City	State	Ownership Percentage	Ownership Percentage	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
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								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
71								71
72								72
73								73
74								74
75								75

VII. RELATED PARTIES

A. (Continued)

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

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		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 - Concordia Village	Springfield, 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 Tipton	Tipton, 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 LI	St. Louis, MO	PACE	16
17					Prime Acquisitions LI	St. Louis, MO	PACE	17
18					Diakon Lutheran Soci	Middleton, PA	Regional Home Off	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	Tipton, 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

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.

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES☒XNO☐

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

Name of Related OrganizationLutheran Senior Services
Street Address1150 Hanley Industrial Court
City / State / Zip CodeSt. Louis, MI 63144
Phone Number(314)-968-9313
Fax Number(314)-968-5590

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	19	Management - Operating	Direct Cost	436,753,747	34	\$ 26,650,439	\$ 17,013,455	10,885,668	\$ 664,237	1
2	30	Management - Capital	Direct Cost	436,753,747	34	560,999		10,885,668	13,982	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					\$ 27,211,438	\$ 17,013,455		\$ 678,219	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3		4		5		6		7		8		9		10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense									
		YES	NO				Original	Balance												
	A. Directly Facility Related Long-Term																			
1	HO Excess Income Offset						\$		\$			\$	(220,809)							1
2	2019C Bonds		X	Campus Expansion	Various	10/31/2010		6,958,618		5,723,094	2/1/2042	Variable						353,774		2
3	2016B Bonds		X					1,913,627		1,719,317										3
4	Interest Income Offset																		(7,006)	4
5	Debt Service Cost																		(33,842)	5
	Working Capital																			
6																				6
7																				7
8																				8
9	TOTAL Facility Related							\$ 8,872,245	\$ 7,442,411					\$ 92,117						9
	B. Non-Facility Related*																			
10	AL/IL Bonds								33,553,815											10
11																				11
12																				12
13																				13
14	TOTAL Non-Facility Related							\$	33,553,815					\$						14
15	TOTALS (line 9+line14)							\$ 8,872,245	\$ 40,996,226					\$ 92,117						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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 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.)		\$	108,428	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	108,428	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.		\$	108,428	7	
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 193,274 9					
2021 196,910 10					
2022 141,679 11					
2023 109,424 12					
2024 108,428 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	<u>Meridian Village Care Center</u>	COUNTY	<u>Madison</u>
---------------	-------------------------------------	--------	----------------

FACILITY IDPH LICENSE NUMBER 0057919

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>14-1-15-28-00-000-005</u>	<u>6.3200 Acres</u>	\$ <u>186,726.00</u>	\$ <u>108,428.00</u>
2.	<u>14-1-15-28-00-000-005.001</u>	<u>10.0900 Acres</u>	\$ <u>155,049.00</u>	\$ _____
3.	<u>14-1-15-28-00-000-005.002</u>	<u>8.6200 Acres</u>	\$ <u>396,698.00</u>	\$ _____
4.	<u>14-2-15-21-04-406-019</u>	<u>1.93 Acres</u>	\$ <u>74,270.00</u>	\$ _____
5.	<u> </u>	<u> </u>	\$ _____	\$ _____
6.	<u> </u>	<u> </u>	\$ _____	\$ _____
7.	<u> </u>	<u> </u>	\$ _____	\$ _____
8.	<u> </u>	<u> </u>	\$ _____	\$ _____
9.	<u> </u>	<u> </u>	\$ _____	\$ _____
10.	<u> </u>	<u> </u>	\$ _____	\$ _____
		TOTALS	\$ <u>812,743.00</u>	\$ <u>108,428.00</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	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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:45,125

B. General Construction Type:ExteriorBrick & SidingFrameWood

Number of Stories1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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)

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

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. 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)?

YESNOX

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☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Senior Living Facility		2003	\$622,399	1
2					2
3	TOTALS			\$622,399	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	70			2010	\$6,248,729	\$174,163	40	\$174,163		\$2,733,913	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2006 Bldg & Bldg Improvements			2006	21,513		Various			21,513	9
10	2007 Bldg & Bldg Improvements			2007	14,905		15			14,905	10
11	2008 Bldg & Bldg Improvements			2008	8,859		Various			8,859	11
12	2009 Bldg & Bldg Improvements			2009							12
13	2010 Bldg & Bldg Improvements			2010	20,817	694	Various	694		20,817	13
14	2011 Bldg & Bldg Improvements			2011	6,446	421	Various	421		6,343	14
15	2012 Bldg & Bldg Improvements			2012	5,578	372	Various	372		5,167	15
16	2013 Bldg & Bldg Improvements			2013	9,431	466	Various	466		5,926	16
17	2014 Bldg & Bldg Improvements			2014							17
18	2015 Bldg & Bldg Improvements			2015	42,111	1,874	Various	1,874		35,522	18
19	2016 Bldg & Bldg Improvements			2016	168,195	4,785	Various	4,785		53,692	19
20	2017 Bldg & Bldg Improvements			2017	21,489	1,213	Various	1,213		16,052	20
21	2018 Bldg & Bldg Improvements			2018	3,568		Various			3,568	21
22	2019 Bldg & Bldg Improvements			2019	12,566	793	Various	793		5,894	22
23	2020 Bldg & Bldg Improvements			2020	8,776	623	Various	623		3,599	23
24	Floor-linoleum/SV/LVT Units 601-611 & Hall			2021	28,594	5,719	5	5,719		28,117	24
25	VG Temp Part & Addtl work			2021	39,159	5,594	7	5,594		22,843	25
26	VG Flooring			2021	58,484	8,355	7	8,355		34,116	26
27	VG Signage			2021	726	104	7	104		423	27
28	VG Corner Guards/Hand Rails			2021	3,484	498	7	498		2,032	28
29	VG Painting & Wallcovering			2021	25,200	3,600	7	3,600		14,700	29
30	VG Plumbing/Mods&BevStation			2021	5,743	383	15	383		1,563	30
31	VG Bar-Com Wander Guard			2021	31,848	2,123	15	2,123		8,670	31
32	VG Tech Electronics Nurse Call			2021	71,832	4,789	15	4,789		19,554	32
33											33
34	Home Office Depreciation Allocation					13,982		13,982			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

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	VG Contractor OH & Fee	2021	\$ 45,328	\$ 3,022	15	\$ 3,022	\$	\$ 12,339	37
38	VG HVAC	2021	17,230	1,149	15	1,149		4,690	38
39	VG Fire X Cabinets	2021	125	8	15	8		34	39
40	VG Doors & Hardware	2021	62,378		15			62,378	40
41	VG Cambria Counter Tops	2021	6,824		15			6,824	41
42	VG CRASH RAILS	2021	19,362	645	30	645		2,635	42
43	VG ActivitiesCenterMedia	2021	135,424	4,514	30	4,514		18,433	43
44	VG General Conditions	2021	49,906	1,664	30	1,664		6,793	44
45	VG Electrical & Lighting	2021	95,900	3,197	30	3,197		13,053	45
46	VG Fire Sprinkler-Allowance	2021	3,500	117	30	117		476	46
47	VG Framing & Drywall	2021	37,720	1,257	30	1,257		5,134	47
48	VG Casework	2021	21,210	707	30	707		2,887	48
49	VG Carpentry	2021	7,808	260	30	260		1,063	49
50	VG Select Demolition	2021	42,419	1,414	30	1,414		5,774	50
51	VG Provident Group	2021	30,000	1,000	30	1,000		4,083	51
52	VG PLAN REVIEW FEES	2021	6,000	200	30	200		817	52
53	VG Architectural Fees	2021	40,049	1,335	30	1,335		5,451	53
54	VG Electrical Survey	2021	5,920	197	30	197		806	54
55	VINTAGE GARDEN RENOVATION PROJECT	2022	30,633	2,042	15	2,042		8,169	55
56	VINTAGE GARDEN CRASH RAIL REPLACE	2022	19,362	1,291	15	1,291		5,163	56
57	CONCRETE & ASPHALT	2022	9,264	618	15	618		2,059	57
58	REACH ROOFING	2023	51,992	3,596	14	3,596		9,889	58
59	WILLOW WAY ROOFING	2023	84,612	5,852	14	5,852		16,094	59
60	INSTALL NURSE CALL SYSTEM	2023	10,036	694	14	694		1,793	60
61	CARECNTR 3 WTR HEATRS/2 MIX VALVS	2023	56,800	3,929	14	3,929		10,149	61
62	CARE CENTER 12TON RTU	2023	9,655	668	14	668		1,614	62
63	CARE CENTER 10 TON DAIKIN RTU	2023	9,655	668	14	668		1,614	63
64	Painting for Memory Care	2024	17,282	2,469	7	2,469		4,526	64
65	Half Wall for Memory Care	2025	4,790	319	15	319		319	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,789,235	\$ 273,383		\$ 273,383	\$	\$ 3,282,847	70

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

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	\$ 572,376	\$ 108,303	\$ 108,303	\$	Various	\$ 346,432	71
72	Current Year Purchases	5,437	656	656		7	656	72
73	Fully Depreciated Assets	533,966	8,493	8,493		Various	529,347	73
74								74
75	TOTALS	\$ 1,111,779	\$ 117,452	\$ 117,452	\$		\$ 876,435	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	2018 Ford Transit 350	2018	\$ 51,556	\$ 6,144	\$ 6,144	\$	7	\$ 51,556	76
77										77
78										78
79										79
80	TOTALS			\$ 51,556	\$ 6,144	\$ 6,144	\$		\$ 51,556	80

E. Summary of Care-Related Assets				1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$ 9,574,969	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 396,979	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 396,979	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 4,210,838	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	\$	\$ 3,771
87	Independent Living	45,798,311	1,563,090	27,482,313
88	Assisted Living	2,721,839	201,514	1,171,907
89	Assisted Living Memory Care	6,332,144	254,305	1,499,970
90				
91	TOTALS	\$ 54,856,065	\$ 2,018,909	\$ 30,157,961

G. Construction-in-Progress		
	Description	Cost
92	CIP	\$
93	Fixed Asset Clearing	232,424
94		
95		\$ 232,424

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description: None in current year
- ☐ YES☒ NO
- (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

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 \$

* 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.

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

☒ 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)	\$					

- (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

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	

- (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						
1	Licensed Occupational Therapist	V10A-03	hrs	\$	5,750	\$ 437,851	\$	5,750	\$ 437,851	1
2	Licensed Speech and Language Development Therapist	V10A-03	hrs		1,593	111,022		1,593	111,022	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-03	hrs		5,824	483,682		5,824	483,682	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 prescripts				257,508		257,508	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Billable Supplies and E</u>	V39-2					133,932		133,932	12
13	Other (specify): <u>Lab, Xray, Hospital</u>	V39-3				43,420			43,420	13
14	TOTAL			\$	13,167	\$ 1,075,975	\$ 391,440	13,167	\$ 1,467,415	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,655,046	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 262,540)	999,501		3
4	Supply Inventory (priced at)	44,197		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,143		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	31,040		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 10,744,927	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,016,449		13
14	Buildings, at Historical Cost	57,363,051		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	5,673,933		16
17	Accumulated Depreciation (book methods)	(34,368,799)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Fixed Asset Clearing	232,424		22
23	Other(specify): Other Assets	541,410		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 31,458,468	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 42,203,395	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 363,830	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	760,657		30
	Accrued Taxes Payable (excluding real estate taxes)	24,885		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	874,406		36
37	Entrance Fees	835,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,858,778	\$	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		40,988,169		43
44		15,424,680		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 56,412,849	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 59,271,627	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (17,068,232)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 42,203,395	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (17,624,706)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (17,624,706)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	556,660	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) Prior Period Adjustment	(186)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 556,474	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)	\$ (17,068,232)	24 *

* This must agree with page 17, line 47.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,329,079	1
2	Discounts and Allowances for all Levels	(1,020,747)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,308,332	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,774,943	6
7	Oxygen	(540)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,774,403	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	16,023	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	663	15
16	Rental of Facility Space		16
17	Sale of Drugs	318,636	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	74,154	19
20	Radiology and X-Ray	11,255	20
21	Other Medical Services	93,844	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 514,575	23
D. Non-Operating Revenue			
24	Contributions	126,310	24
25	Interest and Other Investment Income***	8,218	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 134,528	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		4,684	28
28a		15,557,433	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,562,117	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 26,293,955	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	5,790,019	31
32	Health Care	5,846,878	32
33	General Administration	3,616,753	33
B. Capital Expense			
34	Ownership	811,357	34
C. Ancillary Expense			
35	Special Cost Centers	9,480,251	35
36	Provider Participation Fee	192,037	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 25,737,295	40
41	Income before Income Taxes (line 30 minus line 40)**	556,660	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 556,660	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 438,754.00	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	5,533,741.00	48
49	Medicare Part A	2,151,919.00	49
50	Other-(specify) Managed Care	183,918.00	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)	\$ 8,308,332	56

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	7,139	7,144	\$ 361,242	\$ 50.57	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,991	18,221	955,985	52.47	3
4	Licensed Practical Nurses	13,152	13,542	538,702	39.78	4
5	CNAs & Orderlies	73,890	75,898	1,918,443	25.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	20,470	20,673	604,389	29.24	10
11	Social Service Workers	2,088	2,095	74,847	35.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	79,337	79,771	1,776,797	22.27	15
16	Dishwashers					16
17	Maintenance Workers	18,150	18,291	597,817	32.68	17
18	Housekeepers	23,627	23,842	486,245	20.39	18
19	Laundry					19
20	Administrator	2,080	2,080	156,028	75.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,709	23,645	771,020	32.61	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	1,316	1,322	44,822	33.90	31
32	Other Health C:Transportation	3,056	3,088	80,711	26.14	32
33	Other(specify) Marketing/AL/IL	75,521	75,911	2,311,056	30.44	33
34	TOTAL (lines 1 - 33)	359,526	365,523	\$ 10,678,104 *	\$ 29.21	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	71	32,600	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,832	V10-3	39
40	Physical Therapy Consultant	Monthly	487	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	Mid-America Psychiatric Therapy	Monthly	11,793	V10-3	47
48					48
49	TOTAL (lines 35 - 48)	71	\$ 53,712		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
Christina Frasier	Administrator	0	\$ 156,028	Workers' Compensation Insurance	\$ 69,489		IDPH License Fee	\$ 8,490
				Unemployment Compensation Insurance	799		Advertising: Employee Recruitment	
				FICA Taxes	301,381		Health Care Worker Background Check	
				Employee Health Insurance	346,676		(Indicate # of checks performed 896)	26,663
				Employee Meals			Patient Background Checks	352 3,520
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)	27,016
				Disability Insurance	9,029		Dues and Memberships	150
				Life Insurance	5,805		Licenses	7,348
				Savings & Revenue Sharing	48,008		Subscriptions	1,289
				Dental Insurance	10,522			
							Less: Public Relations Expense	()
							PAC and Lobbying payments	()
							All non-allowable advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 156,028			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 74,476
B. Administrative - Other								
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
LSS Management Fees			\$ 684,857	Description	Line #	Amount	Description	Amount
				N/A			Out-of-State Travel	\$
							In-State Travel	1,303
							Seminar Expense	1,844
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 684,857			TOTAL	\$ 3,147
C. Professional Services								
Vendor/Payee	Type		Amount					
CliftonLarsonAllen LLP	CR/Audit/Tax		\$ 6,809					
Workday	Data Processing		39,293					
Microsoft Corporation	Data Processing		26,671					
SHI International	Data Processing		15,832					
Sirius	Data Processing		13,878					
Palo Alto	Data Processing		10,649					
Kronos	Data Processing		10,436					
Uniguest	Data Processing		10,247					
Relias	Data Processing		9,155					
Fullcount	Data Processing		6,359					
Faxlogic	Data Processing		5,629					
Various	Data Processing		130,928					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 285,886				

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID NumberMeridian Village Care Center

STATE OF ILLINOIS

#0057919

Report Period Beginning:1/1/2025

Ending:12/31/2025

Page 22

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

27,016

27,016Total

(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

27,016

27,016Total

(5)Indicate the total amount of both disposable and non-disposable incontinent expens
and the location of this expense on Sch. V.

\$24,867

Line39

(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.

\$192,037

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 to
the Department, in addition to the daily rate, been properly classified
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.

\$

No

Has any meal income been offset agains
related costs?

Indicate the amount.

\$

(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?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other
times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report?

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

Firm Name:

CliftonLarsonAllen LLP

Yes

(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