		FOR BHF USE				

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: 0045807

Facility Name: Meridian Village Care Center

Address: 27 Auerbach Place (Number) Glen Carbon (City) 62034 (Zip Code)

County: Madison

Telephone Number: (314) 968-9313 **Fax #** (314) 968-5590

HFS ID Number:

Date of Initial License for Current Owners: 12/19/2005

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		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 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 Director
	(Firm Name & Address)	CliftonLarsonAllen LLP 600 Washington Ave. Suite 1800, St. Louis, MO 63101
	(Telephone)	(314) 925-4300 Fax # (314) 925-4350

In the event there are further questions about this report, please contact:
Name: Kevin Wellen, CPA Telephone Number: (314) 925-4300
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,620	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	25,620	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,062	12,577	4,312	18,951	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,062	12,577	4,312	18,951	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.97%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 70 and days of care provided 2,611

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number: Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,157,056	96,916	19,166	1,273,138		1,273,138	(855,474)	417,664			1
2	Food Purchase		729,742		729,742		729,742	(502,311)	227,431			2
3	Housekeeping	349,090	37,043	10,378	396,511		396,511	(256,222)	140,289			3
4	Laundry		9,203	23,367	32,570		32,570		32,570			4
5	Heat and Other Utilities			612,680	612,680		612,680	(537,062)	75,618			5
6	Maintenance	440,638	79,481	357,901	878,020		878,020	(753,878)	124,142			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,946,784	952,385	1,023,492	3,922,661		3,922,661	(2,904,947)	1,017,714			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000	(662)	29,338			9
10	Nursing and Medical Records	2,395,001	165,931	21,868	2,582,800	(1,239)	2,581,561		2,581,561			10
10a	Therapy			578,820	578,820		578,820		578,820			10a
11	Activities	396,642	19,194	54,047	469,883		469,883	(379,754)	90,129			11
12	Social Services	148,198	101		148,299	1,239	149,538	(119,789)	29,749			12
13	CNA Training											13
14	Program Transportation	68,476	3,614	6,286	78,376		78,376	(63,507)	14,869			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,008,317	188,840	691,021	3,888,178		3,888,178	(563,712)	3,324,466			16
	C. General Administration											
17	Administrative	117,718		478,186	595,904		595,904	68,459	664,363			17
18	Directors Fees											18
19	Professional Services			162,669	162,669		162,669	(117,919)	44,750			19
20	Dues, Fees, Subscriptions & Promotions			44,789	44,789	2,082	46,871	(25,742)	21,129			20
21	Clerical & General Office Expenses	567,751	22,707	610,721	1,201,179	(2,082)	1,199,097	(785,742)	413,355			21
22	Employee Benefits & Payroll Taxes			621,171	621,171		621,171		621,171			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,306	6,306		6,306	(3,005)	3,301			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			123,471	123,471		123,471		123,471			26
27	Other (specify):* Marketing	126,517	16,376	146,937	289,830		289,830	(289,830)				27
28	**TOTAL General Administration**	811,986	39,083	2,194,250	3,045,319		3,045,319	(1,153,779)	1,891,540			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,767,087	1,180,308	3,908,763	10,856,158		10,856,158	(4,622,438)	6,233,720			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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			350,585	350,585		350,585	23,468	374,053			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			351,193	351,193		351,193	(75,271)	275,922			32
33	Real Estate Taxes			193,274	193,274		193,274		193,274			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,749	1,749		1,749	(1,076)	673			35
36	Other (specify):*											36
37	TOTAL Ownership			896,801	896,801		896,801	(52,879)	843,922			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		193,142	196,003	389,145		389,145		389,145			39
40	Barber and Beauty Shops			7,508	7,508		7,508	(7,508)				40
41	Coffee and Gift Shops		49		49		49		49			41
42	Provider Participation Fee			128,096	128,096		128,096		128,096			42
43	Other (specify):* AL/IL	1,142,579	32,016	5,053,122	6,227,717		6,227,717	(6,227,717)				43
44	TOTAL Special Cost Centers	1,142,579	225,207	5,384,729	6,752,515		6,752,515	(6,235,225)	517,290			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,909,666	1,405,515	10,190,293	18,505,474		18,505,474	(10,910,542)	7,594,932			45

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(172)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,190)	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	(8,068)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(78,251)	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	(202)	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	453	21		24
25	Fund Raising, Advertising and Promotional	(289,830)	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)**	$ (388,260)		$	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)	25,172		34
35	Other- Attach Schedule	(10,547,454)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,522,282)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (10,910,542)		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

STATE OF ILLINOIS

Meridian Village Care Center

ID# 0045807

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty Income (limited to expense)	$ (7,508)	40	1
2	Transportation Income	(199)	14	2
3	Interest on Past Due Accounts	(448)	32	3
4	Maintenance Services Income	(1,881)	6	4
5	Senior Fit	(205)	11	5
6	IL and IL Direct Expenses	(6,227,717)	43	6
7	Non-SNF Dietary Costs	(855,474)	1	7
8	Non-SNF Food Purchases	(493,033)	2	8
9	Non-SNF Housekeeping	(256,222)	3	9
10	Non-SNF Utilities	(524,872)	5	10
11	Non-SNF Maintenance	(751,997)	6	11
12	Non-SNF Activities	(379,549)	11	12
13	Non-SNF Transportation	(63,308)	14	13
14	Non-SNF Professional Fees	(117,919)	19	14
15	Non-SNF Dues, Fees, Subscriptions, & Promotions	(25,742)	20	15
16	Non-SNF Clerical & Office Expense	(707,742)	21	16
17	Non-SNF Travel & Seminar	(3,005)	24	17
18	Non-SNF Equipment Rental	(1,076)	35	18
19	Non-SNF Social Services	(119,789)	12	19
20	Medical Director Reimbursement	(662)	9	20
21	Liquor	(9,106)	2	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,547,454)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(855,474)	0	0	0	0	0	0	0	0	0	0	(855,474)	1
2	Food Purchase	(502,311)	0	0	0	0	0	0	0	0	0	0	(502,311)	2
3	Housekeeping	(256,222)	0	0	0	0	0	0	0	0	0	0	(256,222)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(537,062)	0	0	0	0	0	0	0	0	0	0	(537,062)	5
6	Maintenance	(753,878)	0	0	0	0	0	0	0	0	0	0	(753,878)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,904,947)	0	0	0	0	0	0	0	0	0	0	(2,904,947)	8
	B. Health Care and Programs													
9	Medical Director	(662)	0	0	0	0	0	0	0	0	0	0	(662)	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	(379,754)	0	0	0	0	0	0	0	0	0	0	(379,754)	11
12	Social Services	(119,789)	0	0	0	0	0	0	0	0	0	0	(119,789)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(63,507)	0	0	0	0	0	0	0	0	0	0	(63,507)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(563,712)	0	0	0	0	0	0	0	0	0	0	(563,712)	16
	C. General Administration													
17	Administrative	0	68,459	0	0	0	0	0	0	0	0	0	68,459	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(117,919)	0	0	0	0	0	0	0	0	0	0	(117,919)	19
20	Fees, Subscriptions & Promotions	(25,742)	0	0	0	0	0	0	0	0	0	0	(25,742)	20
21	Clerical & General Office Expenses	(785,742)	0	0	0	0	0	0	0	0	0	0	(785,742)	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	(3,005)	0	0	0	0	0	0	0	0	0	0	(3,005)	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):*	(289,830)	0	0	0	0	0	0	0	0	0	0	(289,830)	27
28	**TOTAL General Administration**	(1,222,238)	68,459	0	0	0	0	0	0	0	0	0	(1,153,779)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,690,897)	68,459	0	0	0	0	0	0	0	0	0	(4,622,438)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	23,468	0	0	0	0	0	0	0	0	0	23,468	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,516)	(66,755)	0	0	0	0	0	0	0	0	0	(75,271)	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	(1,076)	0	0	0	0	0	0	0	0	0	0	(1,076)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,592)	(43,287)	0	0	0	0	0	0	0	0	0	(52,879)	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	(7,508)	0	0	0	0	0	0	0	0	0	0	(7,508)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(6,227,717)	0	0	0	0	0	0	0	0	0	0	(6,227,717)	43
44	**TOTAL Special Cost Centers**	(6,235,225)	0	0	0	0	0	0	0	0	0	0	(6,235,225)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,935,714)	25,172	0	0	0	0	0	0	0	0	0	(10,910,542)	45

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Board Listing at PG6-Supp		Lutheran Convalscent Home	Webster Groves, MO	Lutheran Senior Servic	St. Louis, MO	Home Office
		Mason Pointe Care Center	Chesterfield, MO	In Home Services & H	St. Louis, MO	HHA/Hospice
		Breeze Park	St. Charles, MO	Richmond Terrace	Richmond Heights, MO	AL
		Heisinger Lutheran Home	Jefferson City, MO	Provident Group	St. Louis, MO	Mgt Co
		Lenoir Woods	Columbia, MO	Affordable Housing	St. Louis, MO	Housing
		Concordia Village Care Center	Springfield, IL	LSS Endowment Fun	St. Louis, MO	Foundation
		Meramec Bluffs	St. Louis, MO	Heisinger Hope Found	Jefferson City, MO	Foundation

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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		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	$ 478,186	Lutheran Senior Services	100.00%	$ 546,645	$ 68,459	1
2	V	30	Management Fee - Capital		Lutheran Senior Services	100.00%	23,468	23,468	2
3	V	32	HO Excess Interest Income		Lutheran Senior Services	100.00%	(66,755)	(66,755)	3
4	V	21	Recruitment	49,641	Lutheran Senior Services	100.00%	49,641		4
5	V	1	Dietician	26,064	Lutheran Senior Services	100.00%	26,064		5
6	V	10	Medical Records	6,619	Lutheran Senior Services	100.00%	6,619		6
7	V	27	Clinical Liaisons	104,223	Lutheran Senior Services	100.00%	104,223		7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 664,733			$ 689,905	$ * 25,172	14

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Anderson, David	BOD	Lutheran Hillside Village	Peoria, IL				1
2	Anderson, Garry	BOD	St. Joseph's Bluffs	Jefferson City, MO				2
3	Bantle, Julie	BOD						3
4	Brown, Dan	BOD						4
5	Christell, Rev. Roy	BOD						5
6	Drollinger, Diane	BOD						6
7	Dunn, Jeffery	BOD						7
8	Komlos, John	BOD						8
9	Kuhlmann, Dr. F Mathew	BOD						9
10	Mueller, Harry	BOD						10
11	Scholl, Rev. Dr. Travis	BOD						11
12	Sombart, Lisa	BOD						12
13	Strand, Sherri	BOD						13
14	Tice, Paul	BOD						14
15	Toon, Norman	BOD						15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management - Operating	Direct Cost	249,622,883	24	$ 15,938,951	$ 12,041,987	8,561,062	$ 546,642	1
2	30	Management - Capital	Direct Cost	249,622,883	24	684,299		8,561,062	23,469	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 16,623,250	$ 12,041,987		$ 570,111	25

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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						$	$			$ (66,755)	1
2	2019C Bonds		X	Campus Expansion	Various	10/31/2010	6,958,618	6,174,452	2/1/2042	Variable	253,836	2
3	2016B Bonds		X				1,913,627	1,854,914			128,695	3
4	Interest Income Offset										(8,516)	4
5	Debt Service Cost										(31,338)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 8,872,245	$ 8,029,366			$ 275,922	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,872,245	$ 8,029,366			$ 275,922	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 Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.

Description	Amount	Line
1. Real Estate Tax accrual used on 2019 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.)	$ 193,274	2
3. Under or (over) accrual (line 2 minus line 1).	$ 193,274	3
4. Real Estate Tax accrual used for 2020 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.	$ 193,274	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2015		8
2016		9
2017		10
2018	177,651	11
2019	187,167	12

FOR BHF USE ONLY

Line	Description	Amount	Line
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** **This denial must be no more than four years old at the time the cost report is filed.**

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meridian Village Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0045807

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	14-1-15-28-00-000-005	6.3200 Acres	$ 156,571.96	$ 133,619.00
2.	14-1-15-28-00-000-005.001	10.0900 Acres	$ 112,907.36	$ 59,655.00
3.	14-1-15-28-00-000-005.002	8.6200 Acres	$ 325,964.60	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 595,443.92	$ 193,274.00

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 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,125 B. General Construction Type: Exterior Brick & Siding Frame Wood Number of Stories 1

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

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

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

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

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

Meridian Village operates 53 assisited living units, 14 assisted living memory care units, 129 independent living apartments, and 34 patio homes
(Meridian Village Association - Independent Living, 55,240 Square Feet; Meridian Village Association III - Assisted Living, 50,790 Square Feet, and Independent Living, 30,716 Square Feet)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	Senior Living Facility		2003	$ 622,399	1
2					2
3	TOTALS			$ 622,399	3

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	70			2010	$ 6,310,444	$ 180,688	40	$ 180,688	$	$ 1,898,712	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2006 Bldg & Bldg Improvements			2006	26,807	1,434	Various	1,434		26,090	9
10	2007 Bldg & Bldg Improvements			2007	14,905	994	15	994		13,414	10
11	2008 Bldg & Bldg Improvements			2008	9,809	591	Various	591		8,333	11
12	2009 Bldg & Bldg Improvements			2009	2,077		7			2,077	12
13	2010 Bldg & Bldg Improvements			2010	25,795	1,388	Various	1,388		19,550	13
14	2011 Bldg & Bldg Improvements			2011	22,518	406	Various	406		20,396	14
15	2012 Bldg & Bldg Improvements			2012	27,892	372	Various	372		25,622	15
16	2013 Bldg & Bldg Improvements			2013	6,482	369	Various	369		3,765	16
17	2014 Bldg & Bldg Improvements			2014	3,558		Various			3,558	17
18	2015 Bldg & Bldg Improvements			2015	47,097	4,447	Various	4,447		27,270	18
19											19
20	Vinyl Flooring Unit 513			2017	430	86	5	86		265	20
21	Vinyl Plank Flooring			2017	702	140	5	140		433	21
22	Carpet Unit 609			2017	1,105	221	5	221		700	22
23	Vinyl Flooring Unit 517			2017	463	93	5	93		293	23
24	Vinyl Flooring Unit 510			2017	397	79	5	79		265	24
25	Carpet-Care Ctr Common Area			2017	1,450	207	7	207		690	25
26	Flooring Rm 520			2017	828	166	5	166		566	26
27	PTAC S#AH110279 Unit 511			2017	692	69	10	69		260	27
28	PTAC S#AH110278 CC Res Room 405			2017	692	69	10	69		260	28
29	PTAC S#AH110276 CC Rem Room 417			2017	692	69	10	69		260	29
30	PTAC S#AH110277 CC Res Room			2017	692	69	10	69		260	30
31	PTAC S#AH110177 CC Res Room			2017	692	69	10	69		260	31
32	PTAC S#HF367642 CC Res Room			2017	692	69	10	69		260	32
33	Secure Care Wandering System			2017	11,962	797	15	797		3,057	33
34	Vinyl Plank Flooring Unit			2018	881	176	5	176		529	34
35	Vinyl Flooring Unit 505			2018	348	70	5	70		209	35
36	V Plank Flooring- Vintage Gardens			2018	670	134	5	134		391	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	V Plank Flooring-VG Rm 518	2018	$ 718	$ 144	5	$ 144	$	$ 419	37
38	Vinyl Plank Flooring	2018	951	190	5	190		491	38
39	Vinyl Flooring Unit 521	2019	357	71	5	71		137	39
40	Fire Alarm Sysem Annunciator	2019	3,517	234	15	234		391	40
41	Floor-linoleum/SV/LVT Unit 503	2019	317	63	5	63		84	41
42	General Electric Upgrades-VG	2019	6,128	409	15	409		579	42
43	Carpet to Tile Reducers	2016	849	170	5	170		821	43
44	Friedrich Vea Series Vtac Qty 3	2016	5,208	347	15	347		1,562	44
45	Pager Qty 10	2016	1,597	106	15	106		470	45
46	Cable For Network E.H.R. Project	2016	340	23	15	23		100	46
47	Cable Drops For E.H.R. Network Proj	2016	1,201	80	15	80		354	47
48	Carpet & V Plank Unity 437	2016	586	117	5	117		498	48
49	Carpet & V Plank Unity 480	2016	1,386	277	5	277		1,178	49
50	Pager Qty 6	2016	952	63	15	63		270	50
51	Carpet Unit 451	2016	2,042	408	5	408		1,701	51
52	Pager Qty 6	2016	950	63	15	63		259	52
53	Cabinets & Countertop	2016	1,323	88	15	88		360	53
54	V Plank Unit 501	2016	1,748	350	5	350		1,428	54
55	V Plank Unit 507	2016	2,426	485	5	485		1,981	55
56	Friedrich VTAC Qty 3	2016	5,208	347	15	347		1,418	56
57	Fire Door Vintage Garden Entrance	2019	2,247	150	15	150		287	57
58	Interior Signage	2020	1,662	111	15	111		111	58
59	Interior Lighting Upgrade	2020	1,998	111	15	111		111	59
60	Drain Down Valve - Care Center	2020	3,085	137	15	137		137	60
61	Grundfos Pump - Care Center	2020	1,655	64	10	64		64	61
62	Floor-linoleum/SV/LVT Unit 511	2020	376	13	5	13		13	62
63									63
64	HO Depreciation Allocation			23,468		23,468			64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,569,599	$ 221,361		$ 221,361	$	$ 2,072,969	70

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

Facility Name & ID Number: Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 659,324	$ 136,415	$ 136,415	$	Various	$ 414,187	71
72	Current Year Purchases	67,561	7,387	7,387		Various	7,387	72
73	Fully Depreciated Assets	811,926	1,511	1,511			811,926	73
74								74
75	TOTALS	$ 1,538,811	$ 145,313	$ 145,313	$		$ 1,233,500	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	$ 7,379	$ 7,379	$	7	$ 15,969	76
77										77
78										78
79										79
80	TOTALS			$ 51,556	$ 7,379	$ 7,379	$		$ 15,969	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,782,365	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 374,053	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 374,053	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)	$ 3,322,438	85	

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Common Area Renovated - 2006	$ 3,771	$ 251	$ 3,645	86
87	Independent Living	42,918,432	1,491,681	23,144,080	87
88	Assisted Living	1,056,291	95,492	550,405	88
89	Assisted Living Memory Care	833,364	54,965	470,126	89
90					90
91	TOTALS	$ 44,811,858	$ 1,642,389	$ 24,168,256	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 640,662	92
93	CIP - Apt Unit Renovation	147,941	93
94			94
95		$ 788,603	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 1,749 Description: Electric heater, healthcare equipment, cylindar related to helium gas
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff 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	$	2,857	$ 219,634	$	2,857	$ 219,634	1
2	Licensed Speech and Language Development Therapist	V10A-3	hrs		972	65,032		972	65,032	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V10A-3	hrs		3,725	294,154		3,725	294,154	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				138,708		138,708	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Billable Supplies and B	V39-2					54,434		54,434	12
13	Other (specify): Lab, Xray, Hospital	V39-2				196,003			196,003	13
14	TOTAL			$	7,554	$ 774,823	$ 193,142	7,554	$ 967,965	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 Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 4,874,625	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	604,883		3
4	Supply Inventory (priced at)	40,156		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	91,827		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	172,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,783,491	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,541,449		13
14	Buildings, at Historical Cost	47,308,043		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,744,731		16
17	Accumulated Depreciation (book methods)	(27,490,694)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **CIP**	788,603		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 26,892,132	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 32,675,623	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 216,154	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	327,435		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,212		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Current Long Term Debt**	765,260		36
37	**Other Current Liabilities**	509,660		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,825,721	$	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**	34,443,233		43
44	**Entrance fees payable and resident deposit**	12,651,971		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 47,095,204	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 48,920,925	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (16,245,302)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 32,675,623	$	48

*(See instructions.)

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (15,562,560)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (15,562,560)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(682,742)	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)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (682,742)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (16,245,302)	24 *

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 7,047,050	1
2	Discounts and Allowances for all Levels	(2,163,351)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,883,699	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,395,099	6
7	Oxygen	(544)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,394,555	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	9,300	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	185,461	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	73,110	19
20	Radiology and X-Ray	16,671	20
21	Other Medical Services	234,680	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 519,222	23
	D. Non-Operating Revenue		
24	Contributions	128,745	24
25	Interest and Other Investment Income***	8,068	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 136,813	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Other Revenue (See WTB)	662,958	28
28a	AL/IL Revenue	10,225,485	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 10,888,443	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,822,732	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,922,661	31
32	Health Care	3,888,178	32
33	General Administration	3,045,319	33
	B. Capital Expense		
34	Ownership	896,801	34
	C. Ancillary Expense		
35	Special Cost Centers	6,624,419	35
36	Provider Participation Fee	128,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,505,474	40
41	**Income before Income Taxes (line 30 minus line 40)****	(682,742)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (682,742)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 326,556	44
45	Private Pay - Net Inpatient Revenue	3,793,892	45
46	Medicare - Net Inpatient Revenue	702,029	46
47	Other-(specify) Managed Care	61,222	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,883,699	49

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

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

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

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

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	7,952	8,094	$ 318,492	$ 39.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,706	10,113	317,041	31.35	3
4	Licensed Practical Nurses	18,189	23,166	601,457	25.96	4
5	CNAs & Orderlies	60,327	67,994	1,124,382	16.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	20,717	21,659	396,642	18.31	10
11	Social Service Workers	6,161	6,321	148,198	23.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	76,576	82,383	1,157,056	14.04	15
16	Dishwashers					16
17	Maintenance Workers	18,552	20,392	440,638	21.61	17
18	Housekeepers	22,500	24,965	349,090	13.98	18
19	Laundry					19
20	Administrator	2,080	2,080	117,718	56.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,122	26,498	567,751	21.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,580	1,590	33,629	21.15	31
32	Other Health Ca Transportation	3,953	4,379	68,476	15.64	32
33	Other(specify) AL/IL/Marketing	68,456	70,418	1,269,096	18.02	33
34	TOTAL (lines 1 - 33)	340,871	370,052	$ 6,909,666 *	$ 18.67	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	30,000	V9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	439	9,225	V39-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	439	$ 39,225		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	170	$ 13,279	V10-3	50
51	Licensed Practical Nurses	63	3,080	V10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	233	$ 16,359		53

Facility Name & ID Number Meridian Village Care Center # 0045807 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Frasier	Administrator	0	$ 117,718
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 117,718

B. Administrative - Other

Description	Amount
LSS Management Fees	$ 478,186
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 478,186

C. Professional Services

Vendor/Payee	Type	Amount
Husch Blackwell	Legal Fees	$ 1,080
CliftonLarsonAllen	Tax/Cost Reports	8,110
Dude Solutions Inventory	Data Processing	3,688
Full Count	Data Processing	6,304
BKD	SNF Billing	637
Touchtown	Data Processing	21,616
Microsoft	Networking Applications	49,970
Sirius	Networking Applications	15,409
Kronos	Payroll	4,389
Workday	Payroll/HR	39,506
Relias	Data Processing	11,960
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 162,669

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 181,982
Unemployment Compensation Insurance	(52,144)
FICA Taxes	195,664
Employee Health Insurance	261,419
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	6,860
Life Insurance	3,736
Savings & Revenue Sharing	11,392
Dental Insurance	12,262
TOTAL (agree to Schedule V, line 22, col.8)	$ 621,171

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		$ 1,990
Advertising: Employee Recruitment		
Health Care Worker Background Check (Indicate # of checks performed	140)	1,442
Patient Background Checks	64	640
Dues and Memberships		6,852
Leading Age		8,264
Licenses		1,941
Less: Public Relations Expense		( )
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 21,129

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	153
Seminar Expense	3,148
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,301

**See instructions.

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Leading Age - $8,264**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? ______

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,215** Line **39**

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

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ______ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ______ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **128,096**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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**

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.