

		FOR BHF USE			

LL2

Supportive Living Facility

2016

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2016)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

I. Facility ID Number: 1000112

Facility Name: Timberlake Senior Living

Address: 2521 Empowerment Dr Springfield 62703

County: Sangamon

Telephone Number: (217) 321-2100 Fax # (217) 321-2130

Federal Employer ID Number: _____

Date Current Owners were Certified: 3/13/2009

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT Charitable Corp.
☐ Trust

☒ PROPRIETARY

☐ Individual
☒ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL

☐ State
☐ County
☐ Other

IRS Exemption Code _____

In the event there are further questions about this report, please contact:

Name: Kenna Hudson

Telephone Number: (314) 587-7924

Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 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) _____

(Type or Print Name) Jerry Doss

(Title) President

Paid Preparer

(Signed) _____

(Print Name and Title) Chuck Schmitz
Chief Financial Officer

(Firm Name & Address) Midwest Christian Villages, Inc
622 Emerson Rd. Suite 310, St. Louis, MO 63141

(Telephone) 314) 587-7900 Fax 314-587-7916

MAIL TO: BUREAU OF HEALTH FINANCE

IL DEPT OF HEALTHCARE AND FAMILY SERVICES

201 S. Grand Avenue East

Springfield, IL 62763-0001

Phone # (217) 782-1630

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	59	Single Unit Apartment	59	21,594	1
2	1	Double Unit Apartment	1	366	2
3		Other			3
4	60	TOTALS	60	21,960	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	19,747	1,106		20,853	5
6	Double Unit		231		231	6
7	Other					7
8	TOTALS	19,747	1,337		21,084	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.01%

D. Indicate the number of paid bed-hold days the SLF had during this year

473 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 18 (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES ☐ NO ☒

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES ☐ NO ☒

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

H. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☐ YES ☐ NO

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? Yes If yes, did the facility make all of the required payments of interest and principle? Yes
If no, explain. _____

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? No If yes, did the facility make all of the required payments of interest and principle? N/A
If no, explain. _____

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facility make all of the required payments of interest and principle? N/A
If no, explain. _____

STATE OF ILLINOIS

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Facility Name: Timberlake Senior Living

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
	A. General Services							
1	Dietary and Food Purchase	160,780	123,295	6,776	290,850		290,850	1
2	Housekeeping, Laundry and Maintenance	55,534	15,776	42,183	113,494		113,494	2
3	Heat and Other Utilities			99,906	99,906	(3,590)	96,316	3
4	Other (specify): Trash			4,152	4,152		4,152	4
5	TOTAL General Services	216,313	139,071	153,017	508,401	(3,590)	504,812	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	295,969	2,426	2,255	300,649		300,649	6
7	Activities and Social Services	23,776	1,737	1,401	26,914		26,914	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	319,745	4,163	3,656	327,564		327,564	9
	C. General Administration							
10	Administrative and Clerical	108,677	4,732	290,873	404,282	(65,449)	338,834	10
11	Marketing Materials, Promotions and Advertising		7,091		7,091		7,091	11
12	Employee Benefits and Payroll Taxes			123,500	123,500		123,500	12
13	Insurance-Property, Liability and Malpractice			46,043	46,043		46,043	13
14	Other (specify): Insurance Loss							14
15	TOTAL General Administration	108,677	11,823	460,416	580,916	(65,449)	515,468	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	644,735	155,058	617,089	1,416,881	(69,038)	1,347,843	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			299,905	299,905	(57,518)	242,387	17
18	Interest			178,324	178,324		178,324	18
19	Real Estate Taxes			6,712	6,712		6,712	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Mortgage Insurance			18,470	18,470		18,470	22
23	TOTAL Ownership			503,411	503,411	(57,518)	445,893	23
24	GRAND TOTAL (Sum of lines 16 and 23)	644,735	155,058	1,120,500	1,920,293	(126,556)	1,793,736	24

Facility Name: Timberlake Senior Living

Report Period Beginning 1/1/2016 Ending: 12/31/2016

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses	1.17	15.29	2
3	Certified Nurse Assistants	9.25	11.19	3
4	Activity Director & Assistants	0.97	11.80	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	7.35	10.52	7
8	Dishwashers			8
9	Maintenance Workers	1.02	15.93	9
10	Housekeepers	1.17	8.99	10
11	Laundry			11
12	Managers	2.00	21.78	12
13	Other Administrative	1.01	11.88	13
14	Clerical			14
15	Marketing			15
16	Other AL Coordinator	0.84	25.05	16
17	Total (lines 1 thru 16)	25	\$ 12.60	17

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5
Midwest Christian Villages, Inc.		St. Louis, MO		Management	

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES ☐ NO ☒

Name of related entity: If yes, what is the value of those services? \$

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES ☒ NO ☐

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties Amount of Fee

1		\$	1
2			2
Total		\$	3

VIII. OWNERSHIP COSTS

A. Purchase price of land _____ Year land was acquired _____

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. *Total units on this schedule must agree with page 2.

	1 Units*	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	
1	60		2009	2009	\$ 7,810,693	\$ 278,953	35	\$ 223,163	\$ (55,790)	\$ 2,231,627	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Landscaping, Engineering, & Soil Survey			2009	83,291	5,553	20	4,165	(1,388)	42,108	6
7	Grading, Seeding, Drain Tile			2010	8,382	559	20	419	(140)	3,679	7
8	Concrete Improvements			2011	12,021	801	20	601	(200)	4,474	8
9	Landscaping			2014	1,800	120	15	120		310	9
10	Carpet			2014	1,106	221	5	221	0	516	10
11	6 Ranges, 2 Convection Ovens			2015	10,840	1,084	10	1,084	(0)	1,807	11
12	LED Lights and Fixtures			2015	9,804	980	10	980		1,634	12
13	Kitchenette Remodel for All Units			2015	16,216	1,081	15	1,081	(0)	1,712	13
14	Carpet - Units 308 and 329			2015	2,526	505	5	505		674	14
15	2 Wall Mount Kitchen Faucets			2016	1,043	61	10	61	0	61	15
16	Driveway 15x10 Landscaping			2016	3,454	173	15	173	0	173	16
17	TOTAL (lines 1 thru 16)				\$ 7,961,177	\$ 290,091		\$ 232,573	\$ (57,518)	\$ 2,288,774	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 539,389	\$ 9,814	\$ 9,814	\$	5	\$ 504,652	18
19	Vehicles	11,523				4	11,523	19
20	TOTAL (lines 18 and 19)	\$ 550,912	\$ 9,814	\$ 9,814	\$		\$ 516,175	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Timberlake Senior Living

Report Period Beginning: 1/1/2016

Ending: 2/31/2016

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

YES

NO

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

8. Is movable equipment rental included in building rental?

YES

NO

9. Rental amount for movable equipment \$

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	See Attached				/ /	\$ 5,215,422	\$ 4,535,501	/ /		\$ 178,324	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 5,215,422	\$ 4,535,501			\$ 178,324	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 5,215,422	\$ 4,535,501			\$ 178,324	10

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

** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

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Facility Name: Timberlake Senior Living

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 142,404	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 24,779)	629,490		3
4	Supply Inventory (priced at)	1,150		4
5	Short-Term Investments			5
6	Prepaid Insurance	35,131		6
7	Other Prepaid Expenses	8,258		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 816,433	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,000		13
14	Buildings, at Historical Cost	7,852,228		14
15	Leasehold Improvements, at Historical Cost	108,949		15
16	Equipment, at Historical Cost	550,912		16
17	Accumulated Depreciation (book methods)	(2,804,949)		17
18	Deferred Charges	128,145		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	209,518		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,119,803	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,936,235	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,029	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,316		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable	9,080		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Accrued Liabilities	32,317		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 107,742	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,526,421		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42	Due to General Partner	704,562		42
43	Accrued Real Estate Taxes	8,600		43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 5,239,583	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 5,347,324	\$	45
46	TOTAL EQUITY	\$ 1,588,911	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,936,235	\$	47

*(See instructions.)

Facility Name: Timberlake Senior Living

Report Period Beginning: 1/1/2016

Ending:

12/31/2016

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

1			
	I. Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,927,268	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,927,268	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	634	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 634	14
	D. Other Revenue (specify):		
15			15
16	Other Miscellaneous Revenue (Attachment)	1,013	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 1,013	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,928,914	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	508,401	19
20	Health Care/ Personal Care	327,564	20
21	General Administration	580,916	21
	B. Capital Expense		
22	Ownership	503,411	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,920,293	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 8,621	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 8,621	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 1,762,374	32
33	Private Pay - Net Inpatient Revenue	64,535	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify) <u>Tax Credit Imp Rev</u>	100,358	35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,927,268	37