

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2014  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2014)**

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.

<p><b>I. Facility ID Number:</b> <u>1000112</u></p> <p><b>Facility Name:</b> <u>Timberlake Senior Living</u></p> <p><b>Address:</b> <u>2521 Empowerment Dr</u> <u>Springfield</u> <u>62703</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Sangamon</u></p> <p><b>Telephone Number:</b> ( <u>217</u> ) <u>321-2100</u> Fax # <u>217 321-2130</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>3/13/2009</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Kenna Hudson</u> <b>Telephone Number:</b> ( <u>314 587-7924</u>  <b>Email Address:</b> <u>khudson.co@christianhomes.org</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other	_____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2014</u> to <u>12/31/2014</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Jerry Doss</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>President</u></td> <td></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Kenna Hudson</u> <u>Controller</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Midwest Chrsitian Villages, Inc</u> <u>622 Emerson Rd. Suite 310, St. Louis, MO 63141</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>314 587-7900</u> Fax <u>314-587-7916</u></td> <td></td> </tr> </table> <p>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</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) <u>Jerry Doss</u>			(Title) <u>President</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) <u>Kenna Hudson</u> <u>Controller</u>		(Firm Name & Address) <u>Midwest Chrsitian Villages, Inc</u> <u>622 Emerson Rd. Suite 310, St. Louis, MO 63141</u>		(Telephone) <u>314 587-7900</u> Fax <u>314-587-7916</u>	
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Facility Name Timberlake Senior Living

Report Period Beginning: 1/1/2014 Ending: 12/31/2014

**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	21,535	1
2	1	Double Unit Apartment	1	365	2
3		Other		365	3
4	60	TOTALS	60	22,265	4

**B. Census-For the entire report period.**

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	18,077	2,585		20,662	5
6	Double Unit	361			361	6
7	Other	361			361	7
8	TOTALS	18,799	2,585		21,384	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.04%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 323 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 21 (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)

None

**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

\* 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. \_\_\_\_\_

Facility Name: Timberlake Senior Living

Report Period Beginning:

1/1/2014

Ending: 12/31/2014

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	174,628	141,904	12,428	328,960	(838)	328,122	1
2	Housekeeping, Laundry and Maintenance	56,155	16,814	40,980	113,949		113,949	2
3	Heat and Other Utilities			107,822	107,822	(4,042)	103,780	3
4	Other (specify): Trash			4,783	4,783		4,783	4
5	<b>TOTAL General Services</b>	<b>230,783</b>	<b>158,718</b>	<b>166,013</b>	<b>555,514</b>	<b>(4,880)</b>	<b>550,634</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	305,371	6,075	4,380	315,826		315,826	6
7	Activities and Social Services	19,003	2,039	3,190	24,232		24,232	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>324,373</b>	<b>8,114</b>	<b>7,570</b>	<b>340,058</b>		<b>340,058</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	127,616	5,255	209,042	341,913	(12,552)	329,361	10
11	Marketing Materials, Promotions and Advertising	31,360	585	6,418	38,363		38,363	11
12	Employee Benefits and Payroll Taxes			122,129	122,129		122,129	12
13	Insurance-Property, Liability and Malpractice			35,178	35,178		35,178	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>158,976</b>	<b>5,841</b>	<b>372,767</b>	<b>537,583</b>	<b>(12,552)</b>	<b>525,031</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>714,132</b>	<b>172,673</b>	<b>546,350</b>	<b>1,433,155</b>	<b>(17,432)</b>	<b>1,415,723</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			343,679	343,679	(74,917)	268,762	17
18	Interest			283,174	283,174		283,174	18
19	Real Estate Taxes			8,554	8,554		8,554	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify): Mortgage Insurance			19,271	19,271		19,271	22
23	<b>TOTAL Ownership</b>			<b>654,676</b>	<b>654,676</b>	<b>(74,917)</b>	<b>579,759</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>714,132</b>	<b>172,673</b>	<b>1,201,026</b>	<b>2,087,831</b>	<b>(92,349)</b>	<b>1,995,482</b>	<b>24</b>

Facility Name: Timberlake Senior Living

Report Period Beginning 1/1/2014

Ending: 12/31/2014

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	2.34	20.23	2
3	Certified Nurse Assistants	9.17	10.86	3
4	Activity Director & Assistants	0.95	9.63	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	7.59	11.06	7
8	Dishwashers			8
9	Maintenance Workers	1.00	16.90	9
10	Housekeepers	1.13	8.88	10
11	Laundry			11
12	Managers			12
13	Other Administrative	3.52	17.43	13
14	Clerical			14
15	Marketing	0.74	20.47	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>26</b>	<b>\$</b>	<b>17</b>

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
<b>Total</b>				<b>\$</b>	<b>6</b>

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$</b>
		<b>3</b>

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
Pathway Senior Living		Des Plaines, IL		Management	
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).

Facility Name: Timberlake Senior Living

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

VIII. OWNERSHIP COSTS

A. Purchase price of land 75,000 Year land was acquired 2007

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	\$ 295,860	35	\$ 223,163	\$ (72,697)	\$ 1,668,648	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Landscaping, Engineering & Soil Survey		2009	83,291	5,953	20	4,125	(1,828)	30,540	6
7		Grading, Seeding, Drain Tile		2010	8,382	559	20	368	(191)	2,515	7
8		Concrete Improvements		2011	12,021	801	20	601	(200)	3,206	8
9		Landscaping		2014	1,800	60	15	60		60	9
10		Carpet		2014	1,106	55	5	55		55	10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 7,917,293	\$ 303,289		\$ 228,372	\$ (74,917)	\$ 1,705,024	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	\$ 501,669	\$ 39,046	\$ 39,046	\$	5	\$ 488,390	18
19	Vehicles	11,523	1,344	1,344	(0)	5	11,523	19
20	TOTAL (lines 18 and 19)	\$ 513,192	\$ 40,390	\$ 40,390	(0)		\$ 499,913	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: **1/1/2014**

Ending:

**12/31/2014****XI. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2014**

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 205,666	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 64,670 )	230,638		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	54,550		6
7	Other Prepaid Expenses	9,039		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 499,893	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,000		13
14	Buildings, at Historical Cost	7,811,799		14
15	Leasehold Improvements, at Historical Cost	105,494		15
16	Equipment, at Historical Cost	513,192		16
17	Accumulated Depreciation (book methods)	(2,204,937)		17
18	Deferred Charges	142,412		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	284,560		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,727,520	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 7,227,413	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 112,985	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,563		30
31	Accrued Taxes Payable	10,488		31
32	Accrued Interest Payable	378		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>Accrued Liabilities</b>	59,738		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 220,153	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	4,642,436		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42	<b>Due to General Partner</b>	704,562		42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 5,346,998	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 5,567,150	\$	45
46	<b>TOTAL EQUITY</b>	\$ 1,660,262	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 7,227,413	\$	47

\*(See instructions.)

Facility Name: Timberlake Senior Living

Report Period Beginning: 1/1/2014

Ending:

12/31/2014

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 1,891,430	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 1,891,430	3
<b>B. Other Operating Revenue</b>			
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	600	8
9	Non-Resident Meals	687	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 1,287	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	564	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 564	14
<b>D. Other Revenue (specify):</b>			
15	See Attached	19,734	15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$ 19,734	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 1,913,015	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	555,514	19
20	Health Care/ Personal Care	340,058	20
21	General Administration	537,583	21
<b>B. Capital Expense</b>			
22	Ownership	654,676	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 2,087,831	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ (174,816)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ (174,816)	31



