

		FOR BHF USE			

LL2

Supportive Living Facility

2013

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2012)

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: 1000131

Facility Name: Lavender Ridge of Effingham

Address: 1103 North Maple Effingham 62401

Number City Zip Code

County: Effingham

Telephone Number: (217) 9943210 Fax #)

Federal Employer ID Number:

Date Current Owners were Certified: 06/21/2011

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL
☐ Charitable Corp.	☐ Individual	☐ State
☐ Trust	☐ Partnership	☐ County
IRS Exemption Code	☒ 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 01/01/2013 to 12/31/2013 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) Mike Dietzen

(Title) President

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

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

Name: Sandy Michels Telephone Number: (217) 994-3210

Email Address:

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

Facility Name **Lavender Ridge of Effingham**

Report Period Beginning: 01/01/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

Date of change in certified units

06/21/2011

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	28	Single Unit Apartment	28	10,220	1		
2		Double Unit Apartment			2		
3		Other			3		
4	28	TOTALS	28	10,220	4		

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	3,913	6,050		9,963	5
6	Double Unit					6
7	Other					7
8	TOTALS	3,913	6,050		9,963	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.49%

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

4 Also, indicate the number of unpaid bed-hold days the SLF had during this year. **(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

ACCUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/13 **Fiscal Year:** 12/31/13

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

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

Facility Name: Lavender Ridge of Effingham

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

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	27,010	50,933	2,458	80,401		80,401	1
2	Housekeeping, Laundry and Maintenance	7,696	14,204		21,900		21,900	2
3	Heat and Other Utilities			19,877	19,877	5,194	25,071	3
4	Other (specify):			1,426	1,426		1,426	4
5	TOTAL General Services	34,706	65,137	23,761	123,604	5,194	128,797	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	327,728	12,437	8,508	348,674		348,674	6
7	Activities and Social Services	11,202	7,424	12,276	30,902		30,902	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	338,930	19,861	20,784	379,576		379,576	9
	C. General Administration							
10	Administrative and Clerical	281,748	4,752	8,292	294,792		294,792	10
11	Marketing Materials, Promotions and Advertising	4,576	769	11,332	16,677		16,677	11
12	Employee Benefits and Payroll Taxes	44,279	1,302		45,581		45,581	12
13	Insurance-Property, Liability and Malpractice		32,085		32,085		32,085	13
14	Other (specify):				11,850		11,850	14
15	TOTAL General Administration	330,603	38,909		400,986		400,986	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	704,239	123,907		904,165	5,194	909,359	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			30,630	30,630		30,630	17
18	Interest			47,615	47,615		47,615	18
19	Real Estate Taxes			35,000	35,000		35,000	19
20	Rent -- Facility and Grounds			3,322	3,322		3,322	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			116,567	116,567		116,567	23
24	GRAND TOTAL (Sum of lines 16 and 23)	704,239	123,907	116,567	1,020,732	5,194	1,025,926	24

Facility Name: Lavender Ridge of Effingham

Report Period Beginning 01/01/2013 Ending: 12/31/2013

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	16.75	2
3	Certified Nurse Assistants	13	9.25	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	9.25	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	0	9.00	10
11	Laundry			11
12	Managers	1	19.00	12
13	Other Administrative	1	23.00	13
14	Clerical	1	19.00	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	19	\$	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

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	Keesha Wood-Smith	15%	40	\$ 48,000	1
2	Sandy Michels	15%	40	39,485	2
3	Michael Dietzen	70%	40	150,000	3
4					4
5					5
Total				\$ 237485	6

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

1	n/a	\$	1
2			2
Total		\$	3

Facility Name: Lavender Ridge of Effingham

Report Period Beginning:

01/01/2013

Ending:

12/31/2013

VIII. OWNERSHIP COSTS

A. Purchase price of land 114,800 Year land was acquired 2010

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	28		2011	2011	\$ 1,588,715	\$	39	\$ 28,307	\$ 28,307	\$ 76,776	1
2											2
3											3
4											4
5											5
	Improvement Type										
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 1,588,715	\$		\$ 28,307	\$ 28,307	\$ 76,776	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	\$ 94,519	\$	\$ 2,323	2,323	39	\$ 6,969	18
19	Vehicles	8,799				1	8,799	19
20	TOTAL (lines 18 and 19)		\$ 103,318	\$	2,323		\$ 15,768	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: Lavender Ridge of Effingham

Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	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	2		3	4	6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1	Midland State Bank		x	Mortgage on Building	4/15/10	\$ 1,800,000	\$ 1,596,435	4/15/16	3.8500	\$ 30,536	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 1,800,000	\$ 1,596,435			\$ 30,536	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 1,800,000	\$ 1,596,435			\$ 30,536	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.

Facility Name: Lavender Ridge of Effingham

Report Period Beginning: 01/01/2013

Ending:

12/31/2013

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

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,207,440	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,207,440	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	12,734	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 12,734	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	4,005	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 4,005	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,224,179	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	128,797	19
20	Health Care/ Personal Care	379,576	20
21	General Administration	400,986	21
	B. Capital Expense		
22	Ownership	116,567	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)	\$ 1,025,926	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 198,253	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 198,253	31

