

		FOR BHF USE			

LL2

Supportive Living Facility

2018

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2018)

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

County: Effingham

Telephone Number: ( 217 ) 994-3210 Fax # ( )

Federal Employer ID Number:

Date Current Owners were Certified: 06/21/11

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code 33

PROPRIETARY

Individual

Partnership

☒ Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

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 01/01/18 to 12/31/18 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) 3/12/2019

(Type or Print Name) Mike Dietzen

(Title) President

Paid Preparer

(Signed)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

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

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

Name: Sandy Michels

Telephone Number: 217-994-3210

Email Address:

HFS 3745C (N-4-05)

IL478-2471

**Report Period Beginning: 01/01/18 Ending: 12/31/18**

### Date of change in certified units

11 / 11

**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 principal? \_\_\_\_\_**  
**If no, explain.**

**33** Also, indicate the number of unpaid bed-hold days the SLF had during this year.    none    (Do not include bed-hold days in Section B.)

## STATE OF ILLINOIS

Facility Name: Lavender Ridge of Effingham

Report Period Beginning:

01/01/18

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## 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	37,888	48,773	3,106	89,767		89,767	1
2	Housekeeping, Laundry and Maintenance	9,233	21,159	673	31,065	6,784	37,849	2
3	Heat and Other Utilities			30,181	30,181		30,181	3
4	Other (specify):			2,444	2,444		2,444	4
5	<b>TOTAL General Services</b>	47,121	69,932	36,404	153,457	6,784	160,241	5
	<b>B. Health Care and Programs</b>							
6	Health Care/ Personal Care	451,129	5,000	5,399	461,528		461,528	6
7	Activities and Social Services		4,902	9,040	13,942		13,942	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	451,129	9,902	14,439	475,470		475,470	9
	<b>C. General Administration</b>							
10	Administrative and Clerical	307,315	5,395	7,571	320,281		320,281	10
11	Marketing Materials, Promotions and Advertising		756	15,713	16,469		16,469	11
12	Employee Benefits and Payroll Taxes	53,174	1,941	40,200	95,315		95,315	12
13	Insurance-Property, Liability and Malpractice		38,300		38,300		38,300	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	360,489	46,392	63,484	470,365		470,365	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	858,739	126,226	114,327	1,099,292	6,784	1,106,076	16
	<b>Capital Expenses</b>							
	<b>D. Ownership</b>							
17	Depreciation			31,065	31,065		31,065	17
18	Interest			25,267	25,267		25,267	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			2,024	2,024		2,024	20
21	Rent -- Equipment							21
22	Other (sp 33)							22
23	<b>TOTAL Ownership</b>			58,356	58,356		58,356	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	858,739	126,226	172,683	1,157,648	6,784	1,164,432	24

Facility Name: Lavender Ridge of Effingham

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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	19.00	2
3	Certified Nurse Assistants	13	11.25	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	11.50	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	10.50	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	20.50	13
14	Clerical	1	23.50	14
15	Marketing	1	20.25	15
16	Other			16
17	Total (lines 1 thru 16)	20	\$ 13.52	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

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	\$ 80,000	1
2	Sandy Michels	15%	40	80,000	2
3	Mike Dietzen	70%	40	150,000	3
4					4
5					5
Total				\$ 310000	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		\$ 3

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 r 33 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).

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	28			2011	\$ 1,588,715	\$	39	\$ 28,307	\$ 28,307	\$ 218,311	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	\$ 218,311	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	\$ 154,045	\$	\$ 2,323	2,323	39	\$ 18,584	18
19	Vehicles	8,799					8,799	19
20	TOTAL (lines 18 and 19)	\$ 162,844	\$	\$ 2,323	2,323		\$ 27,383	20

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

33	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

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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		8. Is movable equipment rental included in building rental?
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*		YES NO
3	Original Building			/ /	\$			3	
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	

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 States Bank		x	Mortgage	9/17/18	\$ 1,163,658	\$ 1,128,028	3/17/27	0.0475	\$ 25,267	1	
2					/ /			/ /			2	
3					/ /			/ /			3	
	Working Capital											
4					/ /			/ /			4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$ 1,163,658	\$ 1,128,028				\$ 25,267	7
	B. Non-Facility Related											
8					/ /			/ /			8	
9	33				/ /			/ /			9	
10	TOTALS (lines 7, 8 and 9)					\$ 1,163,658	\$ 1,128,028				\$ 25,267	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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## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 178,021	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )			3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,574		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	27,913		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 213,508	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	114800		13
14	Buildings, at Historical Cost	1,588,715		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	154,046		16
17	Accumulated Depreciation (book methods)	(245,694)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		1,588,715	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Van	8,799		23
24	<b>TOTAL Long-Term Assets (sum of lines 1 33)</b>	\$ 1,620,666	\$ 1,588,715	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,834,174	\$ 1,588,715	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 22,289	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	135,490		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 157,779	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,128,028		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 1,128,028	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 1,285,807	\$	45
46	<b>TOTAL EQUITY</b>	\$ 548,367	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 1,834,174	\$	47

\*(See instructions.)

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

1			
	I. Revenue	Amount	
	<b>A. SLF Resident Care</b>		
1	Gross SLF Resident Revenue	\$ 1,219,005	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	\$ 1,219,005	3
	<b>B. Other Operating Revenue</b>		
4	Special Services	3,921	4
5	Other Health Care Services	15,577	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	8,960	8
9	Non-Resident Meals	55	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	\$ 28,513	11
	<b>C. Non-Operating Revenue</b>		
12	Contributions		12
13	Interest and Other Investment Income	3,442	13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	\$ 3,442	14
	<b>D. Other Revenue (specify):</b>		
15			15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	\$	17
18	<b>TOTAL R (sum of lines 3, 11, 14 and 17)</b>	\$ 1,250,960	18

2			
	II. Expenses	Amount	
	<b>A. Operating Expenses</b>		
19	General Services	160,241	19
20	Health Care/ Personal Care	475,470	20
21	General Administration	470,365	21
	<b>B. Capital Expense</b>		
22	Ownership	58,356	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 (sum of lines 19 thru 27)</b>	\$ 1,164,432	28
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	\$ 86,528	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	\$ 86,528	31
	<b>III. Net Resident Care Revenue detailed by Payer Source</b>		
32	Medicaid - Net Inpatient Revenue	\$ 342,857	32
33	Private Pay - Net Inpatient Revenue	876,148	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	<b>TOTAL (This total must agree to Line 3)</b>	\$ 1,219,005	37