

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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: 6/21/11

Type of Ownership:

VOLUNTARY, NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

PROPRIETARY

Individual

Partnership

☒ Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

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

Name: Sandy Michels

Telephone Number: 217-994-3210

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 01/01/19 to 12/31/19 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) 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

HFS 3745C (N-4-05)

IL478-2471

Facility Name Lavender Ridge of Effingham Report Period Beginning: 01/01/19 Ending: 12/31/19

III. STATISTICAL DATA

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

Date of change in certified units / /

	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	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	2,880	7,156		10,036	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,880	7,156		10,036	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 98.20%

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

8 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.)

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: 12/31/19 Fiscal Year: 12/31/19

* 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 principal? _____
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 principal? _____
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 principal? _____
If no, explain. _____

STATE OF ILLINOIS

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Facility Name: Lavender Ridge of Effingham

Report Period Beginning:

01/01/19

Ending:

12/31/19

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		53,047	3,805	56,852		56,852	1
2	Housekeeping, Laundry and Maintenance		25,790	225	26,015		26,015	2
3	Heat and Other Utilities			27,098	27,098	5,448	32,546	3
4	Other (specify):			1,889	1,889		1,889	4
5	TOTAL General Services		78,837	33,016	111,853	5,448	117,301	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	552,365	5,000	1,837	559,202		559,202	6
7	Activities and Social Services		4,989	9,120	14,109		14,109	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	552,365	9,989	10,957	573,312		573,312	9
	C. General Administration							
10	Administrative and Clerical	329,894	5,559	8,051	343,504		343,504	10
11	Marketing Materials, Promotions and Advertising		756	21,409	22,165		22,165	11
12	Employee Benefits and Payroll Taxes	58,260	8,978	41,400	108,638		108,638	12
13	Insurance-Property, Liability and Malpractice		32,638		32,638		32,638	13
14	Other (specify):							14
15	TOTAL General Administration	388,154	47,931	70,860	506,944		506,944	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	940,519	136,756	114,833	1,192,108	5,448	1,197,557	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			31,192	31,192		31,192	17
18	Interest			23,888	23,888		23,888	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			3,185	3,185		3,185	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			58,264	58,264		58,264	23
24	GRAND TOTAL (Sum of lines 16 and 23)	940,519	136,756	173,098	1,250,373	5,448	1,255,821	24

Facility Name: Lavender Ridge of Effingham

Report Period Beginning 01/01/19 Ending: 12/31/19

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	19.25	2
3	Certified Nurse Assistants	13	11.40	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	11.75	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	10.75	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	\$ 12.71	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 related entity: If yes, what is the value of 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	\$ 31,192	\$ 31,192	\$ 249,503	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	\$		\$ 31,192	\$ 31,192	\$ 249,503	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	\$ 20,907	18
19	Vehicles	8,799						19
20	TOTAL (lines 18 and 19)		\$ 162,844	\$	\$ 2,323		\$ 20,907	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

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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 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	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	\$ 830,590	3/17/27	0.0475	\$ 23,888	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 1,163,658	\$ 830,590			\$ 23,888	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 1,163,658	\$ 830,590			\$ 23,888	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

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/19

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 205,383	\$	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	7,098		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	35,228		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 247,709	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	114,800		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)	(270,410)		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 (specify):			22
23	Other(specify): van	8,799		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,595,950	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,843,659	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 28,117	\$	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	150,611		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 178,728	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	830,590		39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 830,590	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,009,318	\$	45
46	TOTAL EQUITY	\$ 834,341	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,843,659	\$	47

*(See instructions.)

Facility Name: Lavender Ridge of Effingham

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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	\$ 1,382,722	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,382,722	3
	B. Other Operating Revenue		
4	Special Services	3,827	4
5	Other Health Care Services	11,042	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	9,027	8
9	Non-Resident Meals	112	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 24,008	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	867	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 867	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)	\$ 1,407,597	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	117,301	19
20	Health Care/ Personal Care	573,312	20
21	General Administration	506,944	21
	B. Capital Expense		
22	Ownership	58,264	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)	\$ 1,255,821	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 151,776	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 151,776	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 308,511	32
33	Private Pay - Net Inpatient Revenue	1,074,211	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 1,382,722	37