FOR BHF USE

LL2

Supportive Living Facility

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2017)

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 (Number) Effingham (City) 62401 (Zip Code)

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		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 01/01/2017 to 12/31/2017 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 # ( )

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 Inc. Report Period Beginning: 01/01/2017 Ending: 12/31/2017

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units 06/21/2011

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	2,710	6,214		8,924	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,710	6,214		8,924	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.32%

D. Indicate the number of paid bed-hold days the SLF had during this year 10 **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 [x]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [x]

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

H. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[x]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [ ] YES [ ] NO
Tax Year: 12/31/2017 Fiscal Year: 12/31/2017
* 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: 01/01/2017 Ending: 12/31/2017**

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

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	37,100	47,311	2,832	87,243		87,243	1
2	Housekeeping, Laundry and Maintenance	8,555	21,538	225	30,318		30,318	2
3	Heat and Other Utilities			24,075	24,075	6,345	30,419	3
4	Other (specify):			2,315	2,315		2,315	4
5	**TOTAL General Services**	45,655	68,849	29,447	143,950	6,345	150,295	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	412,549	5,000	3,281	420,830		420,830	6
7	Activities and Social Services	13,101	3,957	9,085	26,143		26,143	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	425,650	8,957	12,366	446,973		446,973	9
	C. General Administration							
10	Administrative and Clerical	286,718	3,379	6,595	296,692		296,692	10
11	Marketing Materials, Promotions and Advertising		962	24,116	25,078		25,078	11
12	Employee Benefits and Payroll Taxes	50,404	1,149	33,900	85,453		85,453	12
13	Insurance-Property, Liability and Malpractice		29,630		29,630		29,630	13
14	Other (specify):							14
15	**TOTAL General Administration**	337,123	35,120	64,611	436,853		436,853	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	808,428	112,926	106,424	1,027,777	6,345	1,034,121	16
	Capital Expenses							
	D. Ownership							
17	Depreciation					30,894	30,894	17
18	Interest			29,801	29,801		29,801	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			2,501	2,501		2,501	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**			32,302	32,302	30,894	63,196	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	808,428	112,926	138,726	1,060,079	37,239	1,097,318	24

Facility Name: Lavender Ridge Lavender Ridge Inc. Report Period Beginning 01/01/2017 Ending: 12/31/2017

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	10.50	3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook	1	11.25	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers	1	10.00	10
11	Laundry			11
12	Managers			12
13	Other Administrative	1	20.00	13
14	Clerical	1	23.50	14
15	Marketing	1	20.00	15
16	Other			16
17	Total (lines 1 thru 16)	20	$ 12.96	17

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	$ 70,000	1
2	Sandy Michels	15%	40	70,000	2
3	Michael Dietzen	70%	40	150,000	3
4					4
5					5
			Total	$ 290000	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1		$	1
2			2
	Total	$	3

VII. RELATED ORGANIZATIONS

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

RELATED SLF's & HEALTH CARE BUSINESSES				OTHER RELATED BUSINESS ENTITIES				
Name	1	City	2	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).

Facility Name: Lav Lavender Ridge Inc. Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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	$ 1,588,715	$	39	$ 28,307	$ 28,307	$ 190,004	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	$ 190,004	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	$ 16,261	18
19	Vehicles	8,799				1	8,799	19
20	TOTAL (lines 18 and 19)	$ 162,844	$	$ 2,323	2,323		$ 25,060	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 Inc. Report Period Beginning: 01/01/2017 Ending: 12/31/2017

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** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	A. Directly Facility Related										
	Long-Term										
1	Midland States Bank		x	Mortgage on Building	4/15/10	$ 1,800,000	$ 1,163,111	4/10/18	3.8500	$ 29,801	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 1,800,000	$ 1,163,111			$ 29,801	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 1,800,000	$ 1,163,111			$ 29,801	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:** 01/01/2017 **Ending:** 12/31/2017

XI. BALANCE SHEET - Lavender Ridge Inc.

As of _____ **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 149,521	$	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	11,242		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	24,027		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 184,790	$	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)	(215,064)		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	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,651,296	$ 1,588,715	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,836,086	$ 1,588,715	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 8,805	$	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	87,456		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)**	$ 96,261	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,163,110		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)**	$ 1,163,110	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 1,259,371	$	45
46	**TOTAL EQUITY**	$ 329,344	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 1,588,715	$	47

***(See instructions.)**

Facility Name: Lavender Ridge of Effingham **Report Period Beginning: 01/01/2017 Ending: 12/31/2017**

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 1,236,163	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,236,163	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	9,399	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 9,399	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$	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)**	$ 1,245,562	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	150,295	19
20	Health Care/ Personal Care	446,973	20
21	General Administration	436,853	21
	B. Capital Expense		
22	Ownership	63,196	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)**	$ 1,097,318	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 148,244	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 148,244	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$ 313,326	32
33	Private Pay - Net Inpatient Revenue	922,837	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$ 1,236,163	37