

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>I. Facility ID Number: <u>1000131</u></p> <p>Facility Name: <u>Lavender Ridge of Effingham</u></p> <p>Address: <u>1103 North Maple</u> <u>Effingham</u> <u>62401</u> <small>Number City Zip Code</small></p> <p>County: <u>Effingham</u></p> <p>Telephone Number: (<u>217</u>) <u>994</u> 3210 Fax # ()</p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>06/21/2011</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input 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 type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" 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>In the event there are further questions about this report, please contact: Name: <u>Sandy Michels</u> Telephone Number: <u>217 994 3210</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input 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 type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" 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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</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" style="width:100%"> <tr> <td rowspan="2" style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Mike Dietzen</u></td> </tr> <tr> <td></td> <td>(Title) <u>President</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td>(Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">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>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Mike Dietzen</u>		(Title) <u>President</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																				
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	(Telephone) () _____ Fax # () _____																																					

Facility Name Lavender Ridge of Effingham

Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	3,322	6,354		9,676	5
6	Double Unit					6
7	Other					7
8	TOTALS	3,322	6,354		9,676	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 94.68%

D. Indicate the number of paid bed-hold days the SLF had during this year 9 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

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? 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:

01/01/14

Ending:

12/31/14

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	27,558	50,424	3,758	81,740		81,740	1
2	Housekeeping, Laundry and Maintenance	7,702	15,696	575	23,973		23,973	2
3	Heat and Other Utilities			24,313	24,313	4,892	29,204	3
4	Other (specify):			2,060	2,060		2,060	4
5	TOTAL General Services	35,260	66,120	30,706	132,086	4,892	136,978	5
B. Health Care and Programs								
6	Health Care/ Personal Care	375,770	12,933	8,929	397,632		397,632	6
7	Activities and Social Services	11,586	3,840	12,803	28,229		28,229	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	387,356	16,773	21,732	425,861		425,861	9
C. General Administration								
10	Administrative and Clerical	253,885	2,325	8,945	265,155		265,155	10
11	Marketing Materials, Promotions and Advertising	4,888	944	15,350	21,182		21,182	11
12	Employee Benefits and Payroll Taxes	44,673	1,175	35,642	81,490		81,490	12
13	Insurance-Property, Liability and Malpractice		38,959		38,959		38,959	13
14	Other (specify):							14
15	TOTAL General Administration	303,446	43,403	59,937	406,785		406,785	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	726,062	126,296	112,375	964,733	4,892	969,624	16
Capital Expenses								
D. Ownership								
17	Depreciation			30,630	30,630		30,630	17
18	Interest			43,506	43,506		43,506	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds			2,908	2,908		2,908	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			77,044	77,044		77,044	23
24	GRAND TOTAL (Sum of lines 16 and 23)	726,062	126,296	189,419	1,041,777	4,892	1,046,668	24

Facility Name: Lavender Ridge of Effingham

Report Period Beginning 01/01/14

Ending: 12/31/14

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	9.50	6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers		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

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	\$ 58,000	1
2	Sandy Michels	15%	40	41,382	2
3	Michael Dietzen	70%	40	150,000	3
4					4
5					5
Total				\$ 249382	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

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).

Facility Name: Lavender Ridge of Effingham

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	\$ 28307	\$ 28,307	\$ 105,083	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	\$ 105,083	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	\$ 9,292	18
19	Vehicles	8,799				1	8,799	19
20	TOTAL (lines 18 and 19)	\$ 103,318	\$	\$ 2,323	2,323		\$ 18,091	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: 01/01/14

Ending: 12/31/14

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	Name of Lender	2		3	4	6		7	8	9	
			Related**	YES			NO	Purpose of Loan				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		Midland States Bank		x	Mortgage on Building	4/15/10	\$ 1,800,000	\$ 1,494,536	4/15/16	3.8500	\$ 43,506	1
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$ 1,800,000	\$ 1,494,536			\$ 43,506	7
		B. Non-Facility Related										
8						/ /			/ /			8
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$ 1,800,000	\$ 1,494,536			\$ 43,506	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: 01/01/14

Ending:

12/31/14

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 39,690	\$	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	934		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	148,326		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 188,950	\$	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)	(123,174)		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)	\$ 1,743,186	\$ 1,588,715	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,932,136	\$ 1,588,715	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,985	\$	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	68,967		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)	\$ 98,952	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,494,536		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)	\$ 1,494,536	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,593,488	\$	45
46	TOTAL EQUITY	\$ 338,648	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,932,136	\$	47

*(See instructions.)

Facility Name: Lavender Ridge of Effingham

Report Period Beginning: 01/01/14

Ending:

12/31/14

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 1,230,458	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,230,458	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	12,330	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 12,330	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	114	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 114	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)	\$ 1,242,902	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	136,978	19
20	Health Care/ Personal Care	425,861	20
21	General Administration	406,785	21
B. Capital Expense			
22	Ownership	77,044	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)	\$ 1,046,668	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 196,234	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 196,234	31

