

		FOR BHF USE			

LL2

Supportive Living Facility

**2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2015)**

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: 100X138

Facility Name: Legacy Memory Support

Address: 4755 E Evergreen Ct Decatur 62521
Number City Zip Code

County: Macon

Telephone Number: (217) 864-4300 **Fax #** ()

Federal Employer ID Number: _____

Date Current Owners were Certified: 2012

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" 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 type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Dave Underwood **Telephone Number:** () _____
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 01/01/15 to 12/31/15 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) <u>David M. Underwood</u>	
	(Title) <u>Exec. VP & CFO</u>	
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 Legacy Memory Support

Report Period Beginning: 01/01/15 Ending: 12/31/15

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	20	Single Unit Apartment	20	7,300	1
2		Double Unit Apartment			2
3		Other			3
4	20	TOTALS	20	7,300	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	2,115	5,096		7,211	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,115	5,096		7,211	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 98.78%

D. Indicate the number of paid bed-hold days the SLF had during this year
None 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)

None

H. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

* 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: Legacy Memory Support

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	50,766	57,642		108,408		108,408	1
2	Housekeeping, Laundry and Maintenance	20,611	7,373		27,985		27,985	2
3	Heat and Other Utilities			42,780	42,780		42,780	3
4	Other (specify):							4
5	TOTAL General Services	71,377	65,015	42,780	179,172		179,172	5
B. Health Care and Programs								
6	Health Care/ Personal Care	142,203	1,042	3,144	146,389		146,389	6
7	Activities and Social Services	11,693	1,268	63	13,024		13,024	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	153,896	2,310	3,207	159,413		159,413	9
C. General Administration								
10	Administrative and Clerical	44,088	3,483	68,687	116,258	(18,627)	97,631	10
11	Marketing Materials, Promotions and Advertising			12,935	12,935		12,935	11
12	Employee Benefits and Payroll Taxes			60,969	60,969		60,969	12
13	Insurance-Property, Liability and Malpractice			8,278	8,278		8,278	13
14	Other (specify):							14
15	TOTAL General Administration	44,088	3,483	150,869	198,440	(18,627)	179,813	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	269,361	70,808	196,855	537,025	(18,627)	518,398	16
Capital Expenses								
D. Ownership								
17	Depreciation			105,032	105,032		105,032	17
18	Interest			115,614	115,614	(380)	115,234	18
19	Real Estate Taxes			42,280	42,280		42,280	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			2,383	2,383		2,383	21
22	Other (specify):							22
23	TOTAL Ownership			265,309	265,309	(380)	264,929	23
24	GRAND TOTAL (Sum of lines 16 and 23)	269,361	70,808	462,165	802,335	(19,007)	783,327	24

Facility Name: Legacy Memory Support

Report Period Beginning 01/01/15

Ending: 12/31/15

V. STAFFING AND SALARY COSTS (Please report each line separately.)

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3.66	\$ 26.80	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	19.88	11.02	3
4	Activity Director & Assistants	1.99	13.07	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	11.38	10.17	7
8	Dishwashers			8
9	Maintenance Workers	0.93	21.50	9
10	Housekeepers	3.09	8.55	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	4.09	17.20	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	45.02	\$ 12.79	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				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	Heritage Operations Group LLC	\$ 43,964	1
2			2
Total		\$ 43,964	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: Legacy Memory Support

Report Period Beginning:

01/01/15

Ending:

12/31/15

VIII. OWNERSHIP COSTS

A. Purchase price of land 528,746 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					\$ 10,601,024	\$ 61,482		\$ 61,482	\$	\$ 1,065,999	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Five (5) Eyewash Station Construction		2013	3,392						6
7		Cable TV Installation-first installment		2013	22,394						7
8		Cable TV Installation-second installment		2014	28,210						8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17		TOTAL (lines 1 thru 16)			\$ 10,655,020	\$ 61,482		\$ 61,482	\$	\$ 1,065,999	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	\$ 615,799	\$ 43,550	\$ 43,550	\$		\$ 754,792	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 615,799	\$ 43,550	\$ 43,550	\$		\$ 754,792	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: Legacy Memory Support

Report Period Beginning: 01/01/15

Ending: 12/31/15

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: None

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**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		A. Directly Facility Related										
		Long-Term										
1		Marine Bank			Mortgage	/ /	\$	11,393,956	/ /		\$	115,614
2						/ /			/ /			2
3						/ /			/ /			3
		Working Capital										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		TOTAL Facility Related					\$	11,393,956			\$	115,614
		B. Non-Facility Related										
8		Interest				/ /			/ /			-380
9						/ /			/ /			9
10		TOTALS (lines 7, 8 and 9)					\$	11,393,956			\$	115,234

* 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: Legacy Memory SupportReport Period Beginning: 01/01/15

Ending:

12/31/15**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/15

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 995,842	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	419,036		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,435		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,442,313	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,985,993		13
14	Buildings, at Historical Cost	10,655,021		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,519,506		16
17	Accumulated Depreciation (book methods)	(1,820,791)		17
18	Deferred Charges	76,514		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,416,243	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,858,556	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 127,254	\$	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	224,747		31
32	Accrued Interest Payable	16,537		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)	\$ 368,538	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,393,956		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)	\$ 11,393,956	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,762,494	\$	45
46	TOTAL EQUITY	\$ 2,096,062	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 13,858,556	\$	47

*(See instructions.)

Facility Name: Legacy Memory Support

Report Period Beginning: 01/01/15

Ending:

12/31/15

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	\$ 1,011,591	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,011,591	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	3,936	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 3,936	11
C. Non-Operating Revenue			
12	Contributions		12
13	Interest and Other Investment Income	380	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 380	14
D. Other Revenue (specify):			
15	Activity Fund	(504)	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ (504)	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,015,403	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	179,172	19
20	Health Care/ Personal Care	159,413	20
21	General Administration	198,440	21
B. Capital Expense			
22	Ownership	265,309	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)	\$ 802,335	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 213,069	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 213,069	31