FOR BHF USE

LL2

Supportive Living Facility

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)

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 (Number) Decatur (City) 62521 (Zip Code)

County: Macon

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

Federal Employer ID Number:

Date Current Owners were Certified: 2012

Type of Ownership:

[ ] VOLUNTARY, NON-PROFIT	[x] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code	[ ] Corporation	[ ] Other
	[ ] "Sub-S" Corp.	
	[x] Limited Liability Co.	
	[ ] Trust	
	[ ] Other	

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

Name: Dave Underwood **Telephone Number:** (309 823-7135

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 01/01/16 to 12/31/16 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) David M. Underwood

(Title) Executive VP & CFO

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: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA

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

	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	20	Single Unit Apartment	20	7,320	1
2		Double Unit Apartment			2
3		Other			3
4	20	TOTALS	20	7,320	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	2,161	5,116		7,277	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,161	5,116		7,277	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 99.41%

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 [x]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [x] 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 [x] MODIFIED CASH* [ ] CASH* [ ]

I. Is your fiscal year identical to your tax year? [x] 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: 01/01/16 Ending: 12/31/16**

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	52,479	59,017		111,496		111,496	1
2	Housekeeping, Laundry and Maintenance	21,212	11,078		32,290		32,290	2
3	Heat and Other Utilities			49,575	49,575		49,575	3
4	Other (specify):							4
5	**TOTAL General Services**	73,691	70,096	49,575	193,361		193,361	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	147,108	1,237	3,494	151,838		151,838	6
7	Activities and Social Services	10,683	2,070		12,753		12,753	7
8	Other (specify):							8
9	**TOTAL Health Care and Programs**	157,790	3,307	3,494	164,591		164,591	9
	C. General Administration							
10	Administrative and Clerical	50,354	3,321	63,014	116,689	(12,788)	103,901	10
11	Marketing Materials, Promotions and Advertising			13,278	13,278		13,278	11
12	Employee Benefits and Payroll Taxes			55,467	55,467		55,467	12
13	Insurance-Property, Liability and Malpractice			8,477	8,477		8,477	13
14	Other (specify):							14
15	**TOTAL General Administration**	50,354	3,321	140,236	193,911	(12,788)	181,123	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	281,835	76,724	193,305	551,863	(12,788)	539,075	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			107,052	107,052		107,052	17
18	Interest			115,075	115,075	(306)	114,769	18
19	Real Estate Taxes			78,390	78,390		78,390	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			3,143	3,143		3,143	21
22	Other (specify):							22
23	**TOTAL Ownership**			303,660	303,660	(306)	303,353	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	281,835	76,724	496,964	855,523	(13,094)	842,429	24

Facility Name: Legacy Memory Support **Report Period Beginning: 01/01/16 Ending: 12/31/16**

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3.19	$ 25.04	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants	19.86	12.11	3
4	Activity Director & Assistants	1.86	13.01	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	11.64	10.08	7
8	Dishwashers			8
9	Maintenance Workers	0.92	21.71	9
10	Housekeepers	3.14	8.53	10
11	Laundry			11
12	Managers			12
13	Other Administrative	4.05	17.32	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	44.65	$ 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				$	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	$ 45,328	1
2			2
		Total $ 45,328	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** [x]

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** [x]

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: 01/01/16 Ending: 12/31/16

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	113				$ 10,601,024	$ 62,605		$ 62,605	$	$	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	Vertical PTAC cooler			2016	4,705						9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				$ 10,659,725	$ 62,605		$ 62,605	$	$	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	$ 1,527,116	$ 44,447	$ 44,447	$		$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	$ 1,527,116	$ 44,447	$ 44,447	$		$	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: 01/01/16 Ending: 12/31/16

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 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

	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	Lancaster Pollard		xx	Mortgage	/ /	$	$ 11,532,646	/ /		$ 115,075	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$	$ 11,532,646			$ 115,075	7
	B. Non-Facility Related										
8	Interest				/ /			/ /		-306	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$	$ 11,532,646			$ 114,769	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: Legacy Memory Support **Report Period Beginning:** 01/01/16 **Ending:** 12/31/16

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,009,258	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	664,112		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,121		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Resident Trust	9,047		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,780,538	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,985,992		13
14	Buildings, at Historical Cost	10,659,725		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,527,116		16
17	Accumulated Depreciation (book methods)	(2,344,271)		17
18	Deferred Charges	217,772		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)**	$ 12,046,334	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,826,872	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 140,642	$	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	311,451		31
32	Accrued Interest Payable	36,039		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	Resident Trust	9,047		35
36				36
37	**TOTAL Current Liabilities (sum of lines 26 thru 36)**	$ 497,179	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	11,532,646		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)**	$ 11,532,646	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 12,029,825	$	45
46	**TOTAL EQUITY**	$ 1,797,047	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 13,826,872	$	47

***(See instructions.)**

Facility Name: Legacy Memory Support **Report Period Beginning: 01/01/16 Ending: 12/31/16**

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	$ 1,027,693	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 1,027,693	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	4,282	8
9	Non-Resident Meals		9
10	Laundry		10
11	**SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)**	$ 4,282	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	306	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 306	14
	D. Other Revenue (specify):		
15	**Activity Fund**	(32)	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ (32)	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 1,032,249	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	193,361	19
20	Health Care/ Personal Care	164,591	20
21	General Administration	193,911	21
	B. Capital Expense		
22	Ownership	303,660	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)**	$ 855,523	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 176,726	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 176,726	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	$	32
33	Private Pay - Net Inpatient Revenue		33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	$	37

Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3, Line #	Sch 5 pg 3, Col #	Sch 6 pg Line #	Adjustment Amount				
PETTY CASH	1,009,258						1,009	1,009	CASH	1,009,258
CASH IN BANK							1,100	1,100	ACCTS RI	827,837
CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. I	-163,725
ACCOUNTS RECEIVABLE	664,112						1,110	1,110	ACCTS RECEIV-M/C	
MEDICARE RECEIVABLES							1,125	1,125	ACCTS RECEIV-IPA	
IPA INCOME RECEIVABLE							1,135	1,135	ACCTS RECEIV-IC	
MEDICARE COST REPORT							1,140	1,140	UNAPPLIED CASH RECEIPTS	
ACCOUNTS RECEIVABLE-IC							1,145	1,145	A/R SUSPENSE-REFUNDS	
UNAPPLIED CASH RECEIPTS							1,200	1,200	PREPAID	98,121
A/R SUSPENSE-REFUNDS							1,220	1,220	OTHER PREPAID EXPENSES	
ACCRUED INTEREST REC							1,300	1,300	DIETARY INVENTORY	
PREPAID INSURANCE	98,121						1,310	1,310	SUPPLIES INVENTORY	
OTHER PREPAID EXPENSES							1,320	1,320	LINEN INVENTORY	
FOOD INVENTORY							1,409	1,409	LAND	1,985,992
SUPPLIES INVENTORY							1,450	1,450	FURNITU	1,527,116
LAND	1,985,992						1,460		ACCUM I	-972,136
FURNITURE & EQUIPMENT	1,527,116						1,475	1,475	BUILDIN(	10,659,725
ACCUM DEPR-FURN & EQUI	-972,136						1,490	1,490	ACCUM I	-1,372,135
BUILDING & IMPROVEMENT	10,659,725						1,530	1,530	RESIDEN	9,047
ACCUM DEPR-BUILDING	-1,372,135						1,550	1,550	LOAN FE	217,772
RESIDENT FUNDS	9,047						1,551	1,551	LOAN FEES ADDED	
LOAN FEES	217,772						1,850	1,850	INTERCO	0
REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUN	-140,642
REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE	
INTRACOMPANY	0						2,100	2,100	ACCRUEI	0
ACCOUNTS PAYABLE	-140,642						2,100	2,100	PR CLEARING-BENEFITS	
BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR	
ACCRUED PAYROLL	0						2,110	2,110	ACCRUEI	0
ACCRUED VACATION PAY	0						2,120	2,120	U.C. TAXES PAYABLE	
UC TAXES PAYABLE							2,125	2,125	FICA TAX	0
FICA TAX PAYABLE	0		0				2,130	2,130	FEDERAL W/H TAX PAYABLE	
FIT PAYABLE							2,140	2,140	STATE W/H TAX PAYABLE	
STATE W/H PAYABLE			0				2,152	2,152	WORKERS COMP ACCRUAL	
EARNED INCOME CREDIT							2,225	2,225	EMPLOYEEE INSURANCE REFUND	
UC FED CREDIT REDUCTION							2,230	2,230	PAYROLL SAVINGS	
PAYROLL SAVINGS							2,235	2,240	UNITED FUND	