

		FOR BHF USE			

LL2

Supportive Living Facility

2020

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2020)

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 Crt Decatur 62521

County: Macon

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

Federal Employer ID Number:

Date Current Owners were Certified: 2012

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

xx PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
xx Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: David M 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 1/1/2020 to 12/31/2020 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) EVP & 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
1. Facility Name	1. Legacy Memory Support

Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	7,320	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 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	2,951	3,675		6,626	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,951	3,675		6,626	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) **90.52%**

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. 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)

None

H. ACCOUNTING BASIS

		MODIFIED	
ACCRUAL	xx	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 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

Page 3

Facility Name: Legacy Memory Support

Report Period Beginning:

1/1/2020

Ending: 12/31/2020

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	57,546	72,957	134	130,637		130,637	1
2	Housekeeping, Laundry and Maintenance	28,901	18,939		47,841		47,841	2
3	Heat and Other Utilities			47,066	47,066		47,066	3
4	Other (specify):							4
5	TOTAL General Services	86,447	91,897	47,200	225,544		225,544	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	201,002	6,000	602	207,604		207,604	6
7	Activities and Social Services	4,033	605		4,637		4,637	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	205,035	6,605	602	212,242		212,242	9
	C. General Administration							
10	Administrative and Clerical	69,417	4,525	64,290	138,232	(2,922)	135,310	10
11	Marketing Materials, Promotions and Advertising			13,932	13,932	(11,251)	2,681	11
12	Employee Benefits and Payroll Taxes			76,175	76,175		76,175	12
13	Insurance-Property, Liability and Malpractice			7,561	7,561		7,561	13
14	Other (specify):							14
15	TOTAL General Administration	69,417	4,525	161,958	235,900	(14,173)	221,727	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	360,899	103,027	209,760	673,686	(14,173)	659,513	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			74,117	74,117		74,117	17
18	Interest			112,911	112,911	(3,435)	109,475	18
19	Real Estate Taxes			26,932	26,932		26,932	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			6,702	6,702		6,702	21
22	Other (specify):							22
23	TOTAL Ownership			220,663	220,663	(3,435)	217,227	23
24	GRAND TOTAL (Sum of lines 16 and 23)	360,899	103,027	430,423	894,349	(17,609)	876,741	24

Facility Name: Legacy Memory Support

Report Period Beginning 1/1/2020 Ending: 12/31/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2.24	\$ 26.36	1
2	Licensed Practical Nurses	1.98	26.07	2
3	Certified Nurse Assistants	22.56	13.50	3
4	Activity Director & Assistants	0.84	9.91	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	10.58	11.23	7
8	Dishwashers			8
9	Maintenance Workers	1.18	22.26	9
10	Housekeepers	3.30	10.17	10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical	6.20	23.12	14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)	48.88	\$ 15.25	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
None			

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).

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	Heritage Enterprises Inc	50.0%		\$ 125,000	1
2	Grand Oaks Estates LLC	50.0%		125,000	2
3					3
4					4
5					5
Total				\$ 250,000	6

VI. (B) Management fees paid to unrelated parties Amount of Fee

1	Heritage Operations Group LLC	\$ 49,765	1
2			2
Total		\$ 49,765	3

Facility Name: Legacy Memory Support

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VIII. OWNERSHIP COSTS

A. Purchase price of land 528,746 Year land was acquired 2012

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					\$	\$ 65,989		\$ 65,989	\$	2,612,632	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	Split system installation			2017	5,957						10
11	Install flooring - common areas			2017	18,113						11
12	Install smoke and CO2 detectors			2017	12,937						12
13	Upgrade phone and fire panel			2017	23,591						13
14	Split system installation			2018	4,383						14
15	Carpet rolls for resident rooms			2019	5,013						15
16	Ductless split system installation - elevator room			2019	3,770						16
17	TOTAL (lines 1 thru 16)				\$ 132,465	\$ 65,989		\$ 65,989	\$	2,612,632	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	\$ 1,492,520	\$ 8,128	\$ 8,128	\$		\$ 1,472,768	18
19	Vehicles	61,196					61,196	19
20	TOTAL (lines 18 and 19)	\$ 1,553,716	\$ 8,128	\$ 8,128	\$		\$ 1,533,964	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

XL OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 5, Carried Forward		\$ 132,465	\$ 65,989		\$ 65,989	\$	\$ 2,612,632	1
2									2
3	Acquire carpet roll for resident rooms	2020	4,907						3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 137,372	\$ 65,989		\$ 65,989	\$	\$ 2,612,632	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name: Legacy Memory Support

Report Period Beginning: 1/1/2020

Ending: 2/31/2020

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

	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	Lancaster Pollard		xx	Mortgage	/ /	\$	10,829,656	/ /		\$ 112,911	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	10,829,656			\$ 112,911	7
	B. Non-Facility Related										
8	Interest Income				/ /			/ /		-3,435	8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	10,829,656			\$ 109,475	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.

STATE OF ILLINOIS

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Facility Name: Legacy Memory Support

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2020

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,748,199	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	164,081		3
4	Supply Inventory (priced <u>FIFO</u>)	23,990		4
5	Short-Term Investments			5
6	Prepaid Insurance	50,867		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,229		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,990,366	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,985,994		13
14	Buildings, at Historical Cost	10,738,396		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,570,414		16
17	Accumulated Depreciation (book methods)	(4,146,596)		17
18	Deferred Charges	209,581		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets - CIP	163,516		22
23	Other(specify): <u>Resident Trust</u>	18,512		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,539,817	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 12,530,183	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 163,780	\$	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	332,661		31
32	Accrued Interest Payable	33,843		32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	<u>Resident Trust</u>	18,512		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 548,796	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	10,829,656		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)	\$ 10,829,656	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 11,378,452	\$	45
46	TOTAL EQUITY	\$ 1,151,731	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 12,530,183	\$	47

*(See instructions.)

Facility Name: Legacy Memory Support

Report Period Beginning: 1/1/2020

Ending:

12/31/2020

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	\$ 1,048,206	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,048,206	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	24,190	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care	624	8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 24,814	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	3,435	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 3,435	14
	D. Other Revenue (specify):		
15	Miscellaneous	(984)	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ (984)	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,075,471	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	225,544	19
20	Health Care/ Personal Care	212,242	20
21	General Administration	235,900	21
	B. Capital Expense		
22	Ownership	220,663	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)	\$ 894,349	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 181,122	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 181,122	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

HFS 27-65C (P4-6-06)