

		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: 1000042

Facility Name: Vistas Fox Valley

Address: 1599 Farnsworth Aurora 60505

Number City Zip Code

County: Kane

Telephone Number: (630) 896-7778 Fax # ()

Federal Employer ID Number: _____

Date Current Owners were Certified: 11/12/2004

Type of Ownership:

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

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

Name: Amanda Springborn Telephone Number: (314) 925-3838

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 06/01/2017 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) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173</u>	
	(Telephone) <u>(847) 517-7070</u> Fax <u>(847) 517-7067</u>	
	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	

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units N/A

	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	123	Single Unit Apartment	123	26,322	1
2	13	Double Unit Apartment	13	2,782	2
3		Other			3
4	136	TOTALS	136	29,104	4

B. Census-For the entire report period.

	1	2	3	4	5	
	Type of Unit	Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	17,684	2,146	206	20,036	5
6	Double Unit	1,228	630		1,858	6
7	Other					7
8	TOTALS	18,912	2,776	206	21,894	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 75.23%

D. Indicate the number of paid bed-hold days the SLF had during this year 414 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 ☒ Note: Non-allowable costs have been eliminated in Scheudle IV, Column 5.

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)
N/A

H. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NO
Tax Year: 12/31/17 Fiscal Year: 12/31/17
* 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. _____

HFS 3745C (N-4-05)

IL478-2471

Facility Name: Vistas Fox Valley

Report Period Beginning:

06/01/2017

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 1	Supplies 2	Other 3	Total 4			
	A. General Services					5	6	
1	Dietary and Food Purchase	143,557	149,787	1,140	294,484	41	294,525	1
2	Housekeeping, Laundry and Maintenance	73,241	27,309	46,306	146,856	3,949	150,805	2
3	Heat and Other Utilities			61,825	61,825	1,064	62,889	3
4	Other (specify):							4
5	TOTAL General Services	216,798	177,096	109,271	503,165	5,054	508,219	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	459,277	11,332		470,609	34	470,643	6
7	Activities and Social Services	24,816		1,905	26,721	4,267	30,988	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	484,093	11,332	1,905	497,330	4,301	501,631	9
	C. General Administration							
10	Administrative and Clerical	146,364		196,165	342,529	12,874	355,403	10
11	Marketing Materials, Promotions and Advertising			3,709	3,709	(3,709)		11
12	Employee Benefits and Payroll Taxes	1,303		124,561	125,864	31,084	156,948	12
13	Insurance-Property, Liability and Malpractice			76,308	76,308	1,091	77,399	13
14	Other (specify):							14
15	TOTAL General Administration	147,667		400,743	548,410	41,340	589,750	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	848,558	188,428	511,919	1,548,905	50,695	1,599,600	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			1,548	1,548		1,548	17
18	Interest			3	3	4,556	4,559	18
19	Real Estate Taxes			140,383	140,383	3,904	144,287	19
20	Rent -- Facility and Grounds			555,314	555,314	37,720	593,034	20
21	Rent -- Equipment			4,102	4,102	2,768	6,870	21
22	Other (specify):							22
23	TOTAL Ownership			701,350	701,350	48,948	750,298	23
24	GRAND TOTAL (Sum of lines 16 and 23)	848,558	188,428	1,213,269	2,250,255	99,643	2,349,898	24

Facility Name: Vistas Fox Valley

Report Period Beginning: 06/01/2017 Ending: 12/31/2017

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	0.02	\$ 27.00	1
2	Licensed Practical Nurses	1.83	28.35	2
3	Certified Nurse Assistants	8.95	13.49	3
4	Activity Director & Assistants	0.60	19.81	4
5	Social Service Workers			5
6	Head Cook	0.10	37.99	6
7	Cook Helpers/Assistants	5.32	12.23	7
8	Dishwashers			8
9	Maintenance Workers	0.57	24.04	9
10	Housekeepers	2.07	10.36	10
11	Laundry			11
12	Managers	0.58	34.02	12
13	Other Administrative	1.16	1.00	13
14	Clerical	1.83	14.97	14
15	Marketing	0.58	17.16	15
16	Other	0.03	23.27	16
17	Total (lines 1 thru 16)	24	\$	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
See Schedule 4A			

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	No owners received compensation from this facility.			\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

		Amount of Fee	
1	N/A	\$	1
2			2
Total		\$	3

OTHER RELATED BUSINESS ENTITIES				
Name	3	City	4	Type of Business 5
See Schedule 4A				

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).

The Vistas - Fox Valley
12/31/2017
Schedule 4A

V.I.A

Owners:

<u>Name</u>	<u>Ownership Interest</u>	<u>Avg. Hours per Work Week</u>	<u>Compensation</u>
Chaim Rajchenbach	50%	N/A	N/A
Menachem Shabat	50%	N/A	N/A

VII. A

Related Organizations: Related SLF's & Health Care Businesses

<u>In State</u>	<u>City</u>
Astoria Place Living & Rehab	Chicago
Bella Terra Morton Grove	Morton Grove
Chalet Living & Rehab Center	Chicago
Elmbrook Nursing	Elmhurst
The Grove of Evanston, LLC	Evanston
The Villa at Evergreen	Evergreen Park
The Grove of Fox Valley	Aurora
The Grove of LaGrange Park, LLC	LaGrange Park
The Grove at the Lake	Zion
Lakefront Nursing & Rehab Center, LLC	Chicago
The Grove at Lincoln Park Living & Rehab	Chicago
Avantara Long-Grove	Long Grove
The Grove North Living & Rehab Center	Skokie
The Grove of Northbrook	Northbrook
Warren Barr North Shore	Highland Park
Avantara Park Ridge	Park Ridge
Peterson Park Association Ltd. Partnership	Chicago
Warren Barr South Loop	Chicago
Warren Barr	Chicago
Aurora Supportive Living	Aurora

<u>Name</u>	<u>City</u>	<u>Type of Business</u>
Legacy Healthcare Financial Services, LLC	Skokie	Management Company
Legacy Real Properties, LLC	Skokie	Real Estate
Grove Healthcare Properties, LLC	Skokie	Real Estate
ReMed Services, LLC	Skokie	Medical Equipment Sales
Progressive Healthcare Consulting	Skokie	Consulting
MG Property Holdings, LLC	Morton Grove	Real Estate
Lifeline Ambulance	Chicago	Ambulance Services
ProPay	Evanston	Payroll Services
ML Design Group	Skokie	Asset Management Fees
ML Enterprise	Skokie	Asset Management Fees
CF St. Louis Inc	Skokie	Management Company

Facility Name: Vistas Fox Valley Report Period Beginning: 06/01/2017 Ending: 12/31/2017

VIII. OWNERSHIP COSTS

A. Purchase price of land N/A Year land was acquired N/A

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									\$	\$	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Patio			2017	13,300	443	15	443		443	6
7	Fence - West Side of Bldg - Dog Walk			2017	5,400	150	15	150		150	7
8	Boiler & Mixing Valve			2017	3,410	57	20	57		57	8
9	Concrete along ramp, wooden fence			2017	4,600	77	15	77		77	9
10	96' fence and 10' wide double gate			2017	5,760	96	15	96		96	10
11	Enlarge patio, Extend fence			2017	4,800	80	15	80		80	11
12	Sidewalk connecting parking lot & city sidewalk			2017	3,700	41	15	41		41	12
13	Vinyl Flooring			2017	4,976	41	10	41		41	13
14	Lighting, Plumbing, Shelving - 103, 106, 122, 225, 506			2017	25,163	105	20	105		105	14
15	Cabinets for Remodeled Rooms 103, 106, 122, 225, 506			2017	2,632	11	20	11		11	15
16	See Attachment I				15,015	182		182		182	16
17	TOTAL (lines 1 thru 16)				\$ 88,756	\$ 1,283		\$ 1,283	\$	\$ 1,283	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	\$ 2,646	\$ 265	\$ 265	\$	5	\$ 265	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$ 2,646	\$ 265	\$ 265	\$		\$ 265	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: Vistas Fox Valley

Report Period Beginning: 06/01/2017

Ending: 2/31/2017

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Tom Neshek

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*		8. Is movable equipment rental included in building rental? ☐ YES ☒ NO
3	Original Building	2004	136	6/01/18	\$ 555,314	10		3	
4	Additions			/ /				4	
5				/ /				5	
6	Allocated from Legacy HC			/ /	37,720			6	
7	TOTAL		136		\$ 593,034			7	

9. Rental amount for movable equipment \$ 6,870

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					/ /	\$		Minimal Interest Expense		\$ 3	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$			\$ 3	7
	B. Non-Facility Related										
8					/ /			Offset Interest Income		(223)	8
9					/ /			Allocated from Mgmt. Co.		4,779	9
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$ 4,559	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: Vistas Fox Valley

Report Period Beginning: 06/01/2017

Ending: 12/31/2017

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,900	\$ 2,900	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 21,597)	1,001,941	1,001,941	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,879	5,879	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See SCH 7A	47,814	47,814	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,058,534	\$ 1,058,534	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	88,756	88,756	15
16	Equipment, at Historical Cost	2,646	2,646	16
17	Accumulated Depreciation (book methods)	(1,548)	(1,548)	17
18	Deferred Charges			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)	\$ 89,854	\$ 89,854	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,148,388	\$ 1,148,388	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 154,541	\$ 154,541	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23	23	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,717	32,717	30
31	Accrued Taxes Payable	1,950	1,950	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35	See SCH 7A	926,568	926,568	35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 1,115,799	\$ 1,115,799	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			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)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,115,799	\$ 1,115,799	45
46	TOTAL EQUITY	\$ 32,589	\$ 32,589	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 1,148,388	\$ 1,148,388	47

*(See instructions.)

Schedule 7A

XI. Balance Sheet

A. Current Assets

Line 9: Other current Assets

<u>Description</u>	<u>Operating</u>	<u>After</u>
		<u>Consolidation</u>
101009 REFUND - TRANSFER	2,841	2,841
101014 REFUND	5,057	5,057
101015 EXCHANGE	372	372
115760 Escrow - R&R	35,938	35,938
118650 SECURITY DEPOSIT	3,606	3,606
	<u>47,814</u>	<u>47,814</u>

XI. Balance Sheet

C. Current Liabilities

Line 35: Other current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After</u>
		<u>Consolidation</u>
120085 DUE TO/FROM - VISTAS FOX VALLEY & MANAGEMENT COMPA	69,604	69,604
120300 DUE TO/FROM - GROVE OF FOX VALLEY & VISTAS	631,409	631,409
140000 DUE TO/FROM PRIOR OWNER	73,015	73,015
140500 DUE TO/FROM OTHERS	30,000	30,000
200100 ACCRUED EXPENSE	8,434	8,434
200117 ACCRUED MANAGEMENT FEES ENTITIES	114,106	114,106
	<u>926,568</u>	<u>926,568</u>

Facility Name: Vistas Fox Valley

Report Period Beginning: 06/01/2017

Ending:

12/31/2017

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	\$ 6,420,934	1
2	Discounts and Allowances	(4,138,813)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,282,121	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		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income	223	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 223	14
	D. Other Revenue (specify):		
15	Rental Income		15
16	Miscellaneous Income	500	16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 500	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 2,282,844	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	503,165	19
20	Health Care/ Personal Care	497,330	20
21	General Administration	548,410	21
	B. Capital Expense		
22	Ownership	701,350	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)	\$ 2,250,255	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 32,589	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 32,589	31
	III. Net Resident Care Revenue detailed by Payer Source		
32	Medicaid - Net Inpatient Revenue	\$ 2,011,131	32
33	Private Pay - Net Inpatient Revenue	270,990	33
34	Medicare - Net Inpatient Revenue		34
35	Other-(specify)		35
36	Other-(specify)		36
37	TOTAL (This total must agree to Line 3)	\$ 2,282,121	37

Improvement Type	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
Remove old A/C & Install New Unit	2017		4,500	113	20	113	-	113	18
Mixing Valve Replacement	2017		3,543	44	20	44	-	44	19
Electrical Work on East/West Stairwell Doors	2017		3,000	25	20	25	-	25	20
Repipe at Water Boiler & Mixing Valve	2017		3,972		20	-	-	0	21
							-		22
							-		23
							-		24
							-		25
							-		26
							-		27
							-		28
							-		29
							-		30
							-		31
							-		32
							-		33
							-		34
							-		35
							-		36
							-		37
							-		38
							-		39
							-		40
							-		41
							-		42
							-		43
							-		44
							-		45
Total (Attachment 1) to Schedule VIII - Line 16			\$ 15,015	\$ 182		\$ 182	\$ -	\$ 182	46