

FOR BHF USE							

LL2

Supportive Living Facility
2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2010)

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: 1000052

Facility Name: Friedman Place

Address: 5527 North Maplewood Chicago 60625
 Number City Zip Code

County: cook

Telephone Number: (773) 989-9800 Fax # 773 989-4889

Federal Employer ID Number: _____

Date Current Owners were Certified: 10-07-05

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: Rita Scaletta **Telephone Number:** (773) 989-9800
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 070109 to 063010 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>Ann Lagory</u>	
Paid Preparer	(Title) <u>Executive Director</u>	
	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (<u> </u>) <u> </u> Fax # (<u> </u>) <u> </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

Facility Name Friedman PlaceReport Period Beginning: 070109Ending: 063010

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	<u>74</u>	Single Unit Apartment	<u>74</u>	<u>27,010</u>	1
2	<u>7</u>	Double Unit Apartment	<u>7</u>	<u>2,555</u>	2
3		Other			3
4	<u>81</u>	TOTALS	<u>81</u>	<u>29,565</u>	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	<u>20,045</u>	<u>3,746</u>		<u>23,791</u>	5
6	Double Unit	<u>1,452</u>	<u>732</u>		<u>2,184</u>	6
7	Other					7
8	TOTALS	<u>21,497</u>	<u>4,478</u>		<u>25,975</u>	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 87.86%

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

0 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 125 (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 ☒ NOTax Year: 2009 Fiscal Year: 2010

* 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. _____

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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	307,936	235,745	13,348	557,029		557,029	1
2	Housekeeping, Laundry and Maintenance	110,127	15,388	93,985	219,500		219,500	2
3	Heat and Other Utilities			155,979	155,979		155,979	3
4	Other (specify): scavenger, pest control, landscaping			23,448	23,448	72,801	96,249	4
5	TOTAL General Services	418,063	251,133	286,760	955,956	72,801	1,028,757	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	611,736	8,397	46,246	666,379		666,379	6
7	Activities and Social Services	230,291		88,415	318,706		318,706	7
8	Other (specify): Dental			2,354	2,354		2,354	8
9	TOTAL Health Care and Programs	842,027	8,397	137,015	987,439		987,439	9
	C. General Administration							
10	Administrative and Clerical	428,028	25,416	66,883	520,327		520,327	10
11	Marketing Materials, Promotions and Advertising		12,134	12,134	24,267		24,267	11
12	Employee Benefits and Payroll Taxes	139,418		176,261	315,679		315,679	12
13	Insurance-Property, Liability and Malpractice			42,100	42,100		42,100	13
14	Other (specify): Telephone			12,356	12,356		12,356	14
15	TOTAL General Administration	567,446	37,550	309,734	914,729		914,729	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,827,536	297,080	733,509	2,858,124	72,801	2,930,925	16
	Capital Expenses							
	D. Ownership							
17	Depreciation				222,258		222,258	17
18	Interest				12,214		12,214	18
19	Real Estate Taxes				768		768	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership				235,240		235,240	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,827,536	297,080	733,509	3,093,364	72,801	3,166,165	24

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 37.08	1
2	Licensed Practical Nurses	2	25.00	2
3	Certified Nurse Assistants	12	12.06	3
4	Activity Director & Assistants	4	18.21	4
5	Social Service Workers			5
6	Head Cook	1	24.05	6
7	Cook Helpers/Assistants	9	13.26	7
8	Dishwashers			8
9	Maintenance Workers	1	19.38	9
10	Housekeepers	4	11.25	10
11	Laundry			11
12	Managers	6	28.65	12
13	Other Administrative	2	11.88	13
14	Clerical			14
15	Marketing	1	27.50	15
16	Other			16
17	Total (lines 1 thru 16)	41	\$	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

<u>Name</u>	<u>1</u>	<u>City</u>	<u>2</u>

OTHER RELATED BUSINESS ENTITIES

<u>Name</u>	<u>3</u>	<u>City</u>	<u>4</u>	<u>Type of Business</u>	<u>5</u>

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				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

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

1		\$	1
2			2
Total		\$	3

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VIII. OWNERSHIP COSTS

A. Purchase price of land 1,000,000 Year land was acquired 2004

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	81		2004		\$ 5,845,715	\$ 212,570	28	\$ 212,571	\$	1,355,164	1
2											2
3											3
4											4
5											5
Improvement Type											
6	Deaf/Blind Rooms				4,822	176	28	172	(4)	972	6
7	Chiller				7,400	269	28	264	(5)	1,357	7
8	Kitchen Ducts				2,983	108	28	107	(1)	610	8
9	Elevator				4,441	162	28	159	(3)	796	9
10	Laundry Room				9,403	342	28	336	(6)	1,610	10
11	Water pump				6,010	218	28	215	(3)	865	11
12	Gemini Computers				1,924	70	28	69	(1)	277	12
13	Chillers				17,080	1,032	28	610	(422)	2,767	13
14	Plumbing				8,250	300	28	295	(5)	1,188	14
15	Dog Run				3,800	253	28	136		633	15
16	Smoke Alarms				9,669	645	28	345	(300)	1,612	16
17	Roof				23,310	1,114	28	833	(282)	2,368	17
18	2nd floor office				11,211	408	28	400		527	18
19	Fence				4,200	140	28	150	10	2,310	19
	TOTAL (lines 1 thru 16)				\$ 5,960,218	\$ 217,807		\$ 215,278	\$ (1,023)	\$ 1,373,056	

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	\$ 98,479	\$ 7,801	\$		5	\$ 85,016	18
19	Vehicles	24,604	256			5	24,604	19
20	TOTAL (lines 18 and 19)	\$ 123,083	\$ 8,057	\$	\$		\$ 109,620	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

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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		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	KAGAN HOME	X		TO PURCHASE BUILDING	03/03/05	\$ 1,700,000	\$ 1,700,000	03/31/35	7.0000	\$	1	
2					/ /			/ /			2	
3					/ /			/ /			3	
	Working Capital											
4	MB Financial Bank		x	TO COVER OPERATING EXPENSES	10/01/06	593,242	360,632	10/01/16	3.2500	12,214	4	
5					/ /			/ /			5	
6					/ /			/ /			6	
7	TOTAL Facility Related					\$ 2,293,242	\$ 2,060,632				\$ 12,214	7
	B. Non-Facility Related											
8					/ /			/ /			8	
9					/ /			/ /			9	
10	TOTALS (lines 7, 8 and 9)					\$ 2,293,242	\$ 2,060,632				\$ 12,214	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.

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 063010

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 216,658	\$	1
2	Cash-Patient Deposits	3,033		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	253,725		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,868		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)	\$ 479,284	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,000,000		13
14	Buildings, at Historical Cost	4,100,000		14
15	Leasehold Improvements, at Historical Cos	1,860,219		15
16	Equipment, at Historical Cost	123,083		16
17	Accumulated Depreciation (book methods)	(1,246,239)		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)	\$ 5,837,063	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,316,347	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 44,152	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,003		28
29	Short-Term Notes Payable	360,632		29
30	Accrued Salaries Payable	42,885		30
31	Accrued Taxes Payable			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)	\$ 450,672	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,450,000		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)	\$ 2,450,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,900,672	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,900,672	\$	47

*(See instructions.)

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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	\$ 2,664,756	1
2	Discounts and Allowances		2
	SUBTOTAL Resident Care		
3	(line 1 minus line 2)	\$ 2,664,756	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
	SUBTOTAL OTHER OPERATING REVENUE		
11	(sum of lines 4 thru 10)	\$	11
	C. Non-Operating Revenue		
12	Contributions	340,823	12
13	Interest and Other Investment Income	485	13
	SUBTOTAL Non-Operating Revenue		
14	(sum of lines 12 and 13)	\$ 341,308	14
	D. Other Revenue (specify):		
15			15
16			16
	SUBTOTAL Other Revenue		
17	(sum of lines 15 and 16)	\$	17
	TOTAL REVENUE		
18	(sum of lines 3, 11, 14 and 17)	\$ 3,006,064	18

		2	
	Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,028,757	19
20	Health Care/ Personal Care	987,439	20
21	General Administration	914,729	21
	B. Capital Expense		
22	Ownership	235,240	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
	TOTAL EXPENSES		
28	(sum of lines 19 thru 27)	\$ 3,166,165	28
	Income Before Income Taxes		
29	(line 18 minus line 28)	\$ (160,101)	29
	Income Taxes		
30		\$	30
	NET INCOME OR LOSS FOR THE YEAR		
31	(line 29 minus line 30)	\$ (160,101)	31