

		FOR BHF USE			

LL2

Supportive Living Facility

2012

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2012)

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

☒ Charitable Corp.

☐ Trust

IRS Exemption Code

☐ PROPRIETARY

☐ Individual

☐ Partnership

☒ Corporation

☐ "Sub-S" Corp.

☐ Limited Liability Co.

☐ Trust

☐ Other

☐ GOVERNMENTAL

☐ State

☐ County

☐ 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 07/01/11 to 06/30/12 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) Ann Lagory

(Title) Executive Director

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 Friedman Place

Report Period Beginning: 07/01/11 Ending: 06/30/12

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	74	Single Unit Apartment	74	27,010	1
2	7	Double Unit Apartment	7	2,555	2
3		Other			3
4	81	TOTALS	81	29,565	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	24,525	3,436		27,961	5
6	Double Unit	730			730	6
7	Other					7
8	TOTALS	25,255	3,436		28,691	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.04%

D. Indicate the number of paid bed-hold days the SLF had during this year 521 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 101 (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 NO x

G. List all services provided by your facility for non-residents. (E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL x MODIFIED CASH* CASH*

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

Tax Year: 2011 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.

Facility Name: Friedman Place

Report Period Beginning:

07/01/11

Ending:

06/30/12

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	323,809	259,794	6,015	589,618	61,518	651,136	1
2	Housekeeping, Laundry and Maintenance	141,095	19,738	111,557	272,390		272,390	2
3	Heat and Other Utilities			140,496	140,496		140,496	3
4	Other (specify):scavenger, pest control, landscaping			36,226	36,226		36,226	4
5	TOTAL General Services	464,904	279,532	294,294	1,038,730	61,518	1,100,248	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	646,914	11,027	43,275	701,216		701,216	6
7	Activities and Social Services	170,546	2,808	87,320	260,674	8,230	268,904	7
8	Other (specify): Dental			3,339	3,339		3,339	8
9	TOTAL Health Care and Programs	817,460	13,835	133,934	965,229	8,230	973,459	9
	C. General Administration							
10	Administrative and Clerical	488,201	26,205	78,920	593,326		593,326	10
11	Marketing Materials, Promotions and Advertising		16,207	25,291	41,498		41,498	11
12	Employee Benefits and Payroll Taxes	449,837			449,837		449,837	12
13	Insurance-Property, Liability and Malpractice			34,811	34,811		34,811	13
14	Other (specify): Telephone			11,691	11,691		11,691	14
15	TOTAL General Administration	938,038	42,412	150,713	1,131,163		1,131,163	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	2,220,402	335,779	578,941	3,135,122	69,748	3,204,870	16
	Capital Expenses							
	D. Ownership							
17	Depreciation				246,939		246,939	17
18	Interest				131,770		131,770	18
19	Real Estate Taxes				494		494	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership				379,203		379,203	23
24	GRAND TOTAL (Sum of lines 16 and 23)	2,220,402	335,779	578,941	3,514,325	69,748	3,584,073	24

Facility Name: Friedman Place

Report Period Beginning 07/01/11 Ending: 06/30/12

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 40.72	1
2	Licensed Practical Nurses	3	25.52	2
3	Certified Nurse Assistants	15	12.64	3
4	Activity Director & Assistants	4	21.53	4
5	Social Service Workers			5
6	Head Cook	1	18.63	6
7	Cook Helpers/Assistants	12	11.38	7
8	Dishwashers			8
9	Maintenance Workers	2	18.57	9
10	Housekeepers	3	11.65	10
11	Laundry			11
12	Managers	4	32.87	12
13	Other Administrative	2	18.70	13
14	Clerical	2	10.13	14
15	Marketing	2	24.74	15
16	Other			16
17	Total (lines 1 thru 16)	51	\$	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

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				\$	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

Facility Name: Friedman Place

Report Period Beginning:

07/01/11

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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	\$	\$ 1,567,736	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Deaf/Blind Rooms				4,822	176	28	172	(4)	1,147	6
7	Chiller				7,400	269	28	264	(5)	1,626	7
8	Kitchen Ducts				2,983	108	28	107	(1)	719	8
9	Elevator				4,441	162	28	159	(3)	958	9
10	Laundry Room				9,403	342	28	336	(6)	1,952	10
11	Water pump				6,010	218	28	215	(3)	1,084	11
12	Gemini Compuers				1,924	70	28	69	(1)	347	12
13	Chillers				51,591	1,032	28	1,843	811	38,310	13
14	Plumbing				15,012	1,128	15	536	(592)	6,180	14
15	Dog Run				3,800	253	15	136		887	15
16	Smoke Alarms				9,669	645	15	345	(300)	2,256	16
17	Roof				138,010	4,921	28	4,929	8	8,275	17
18	2nd floor office				15,644	407	28	559		5,367	18
19	Fence				4,200	252	15	150	(102)	663	19
	TOTAL (lines 1 thru 16)				\$ 6,120,624	\$ 222,553		\$ 216,752	\$ (199)	\$ 1,637,507	

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	\$ 126,427	\$ 20,161	\$		5	\$ 113,971	18
19	Vehicles	33,585	4,221			5	30,225	19
20	TOTAL (lines 18 and 19)	\$ 160,012	\$ 24,382	\$	\$		\$ 144,196	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: Friedman Place

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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 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	KAGAN HOME	X		TO PURCHASE BUILDING	03/03/05	\$ 1,700,000	\$ 1,700,000	03/31/35	7.0000	\$ 122,893	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	MB Financial Bank		x	TO COVER OPERATING EXPENSES	10/01/06	593,242	133,209	6/1/18	3.2500	8,877	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 2,293,242	\$ 1,833,209			\$ 131,770	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 2,293,242	\$ 1,833,209			\$ 131,770	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: Friedman Place

Report Period Beginning: 07/01/11

Ending:

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/12

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 21,579	\$	1
2	Cash-Patient Deposits	27,033		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	420,820		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			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)	\$ 469,432	\$	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 Cost	2,020,624		15
16	Equipment, at Historical Cost	160,012		16
17	Accumulated Depreciation (book methods)	(1,781,703)		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)	\$ 5,498,933	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,968,365	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 30,172	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,315		28
29	Short-Term Notes Payable	54,767		29
30	Accrued Salaries Payable	57,990		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)	\$ 170,244	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,528,442		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)	\$ 2,528,442	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,698,686	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,698,686	\$	47

*(See instructions.)

Facility Name: Friedman Place

Report Period Beginning: 07/01/11

Ending:

06/30/12

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 2,886,616	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 2,886,616	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	819,961	12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 819,961	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,706,577	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,100,248	19
20	Health Care/ Personal Care	973,459	20
21	General Administration	1,131,163	21
	B. Capital Expense		
22	Ownership	379,203	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)	\$ 3,584,073	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 122,504	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 122,504	31

