

		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: 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
		☒	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☐	Limited Liability Co.		
		☐	Trust		
		☐	Other		

IRS Exemption Code

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 070116 to 063017 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)	Rita Scaletta	
Paid Preparer	(Title)	Director of Finance and Operations	
	(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

Report Period Beginning: 070116 Ending: 063017

Date of change in certified units / /

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.

688 Also, indicate the number of unpaid bed-hold days the SLF
had during this year. **46 (Do not include bed-hold days in Section B.)**

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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	359,153	282,628	1,500	643,281	(1,543)	641,738	1
2	Housekeeping, Laundry and Maintenance	142,088	30,891	132,031	305,011		305,011	2
3	Heat and Other Utilities			121,461	121,461		121,461	3
4	Other (specify):			17,725	17,725		17,725	4
5	TOTAL General Services	501,241	313,519	272,717	1,087,477	(1,543)	1,085,935	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	587,339	16,188	17,989	621,515		621,515	6
7	Activities and Social Services	274,113		44,456	318,569		318,569	7
8	Other (specify):			1,543	1,543		1,543	8
9	TOTAL Health Care and Programs	861,452	16,188	63,987	941,627		941,627	9
	C. General Administration							
10	Administrative and Clerical	479,330	17,721	67,494	564,545		564,545	10
11	Marketing Materials, Promotions and Advertising			13,187	13,187		13,187	11
12	Employee Benefits and Payroll Taxes	481,284			481,284		481,284	12
13	Insurance-Property, Liability and Malpractice			37,408	37,408		37,408	13
14	Other (specify): telephone			16,375	16,375		16,375	14
15	TOTAL General Administration	960,614	17,721	134,464	1,112,799		1,112,799	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	2,323,307	347,428	471,169	3,141,904	(1,543)	3,140,361	16
	Capital Expenses							
	D. Ownership							
17	Depreciation				291,115		291,115	17
18	Interest							18
19	Real Estate Taxes				472		472	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership				291,587		291,587	23
24	GRAND TOTAL (Sum of lines 16 and 23)	2,323,307	347,428	471,169	3,433,490	(1,543)	3,431,947	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	2	\$ 32.86	1
2	Licensed Practical Nurses	2	25.94	2
3	Certified Nurse Assistants	11	13.69	3
4	Activity Director & Assistants	3	16.24	4
5	Social Service Workers	2	29.32	5
6	Head Cook	1	19.00	6
7	Cook Helpers/Assistants	14	12.68	7
8	Dishwashers			8
9	Maintenance Workers	1	17.38	9
10	Housekeepers	4	11.95	10
11	Laundry			11
12	Managers	3	52.55	12
13	Other Administrative	4	15.77	13
14	Clerical			14
15	Marketing			15
16	Other	2	23.40	16
17	Total (lines 1 thru 16)	50	\$	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

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

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? \$

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).

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VIII. OWNERSHIP COSTS

A. Purchase price of land 1,028,500 Year land was acquired 2004 & 2016

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		\$ 4,100,000	\$ 149,117	28	\$ 149,091	\$	1,845,041	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	various years purchases #2				2,037,367	74,099	28	74,086	(13)	907,994	6
7	building improvements				795,937	29,138	28	28,943	(195)	44,959	7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 6,933,304	\$ 252,354		\$ 252,120	\$ (208)	\$ 2,797,994	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	\$ 321,746	\$ 37,846	\$		5	\$ 206,640	18
19	Vehicles	36,361	915			5	37,961	19
20	TOTAL (lines 18 and 19)	\$ 358,107	\$ 38,761	\$	\$		\$ 244,601	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 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	AJB	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					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 1,700,000	\$ 1,700,000			\$ 122,893	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 1,700,000	\$ 1,700,000			\$ 122,893	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 063017

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 47,228	\$	1
2	Cash-Patient Deposits	9,796		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	732,599		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,028		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,028		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 796,679	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,028,500		13
14	Buildings, at Historical Cost	4,388,639		14
15	Leasehold Improvements, at Historical Cost	2,517,802		15
16	Equipment, at Historical Cost	345,648		16
17	Accumulated Depreciation (book methods)	(3,042,599)		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)	\$ 5,237,991	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,034,670	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 66,616	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,596		28
29	Short-Term Notes Payable	414		29
30	Accrued Salaries Payable	64,131		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)	\$ 140,756	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,075,000		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)	\$ 2,075,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,215,756	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,215,756	\$	47

*(See instructions.)

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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	\$ 3,084,039	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,084,039	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	496,533	12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 496,533	14
	D. Other Revenue (specify):		
15	cell tower	25,895	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 25,895	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,606,467	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,085,935	19
20	Health Care/ Personal Care	941,627	20
21	General Administration	1,112,799	21
	B. Capital Expense		
22	Ownership	414,480	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):	1,543	25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 3,556,383	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 50,084	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 50,084	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