

		FOR BHF USE			

LL2

Supportive Living Facility

2018

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:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input checked="" type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	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 070117 to 063018 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

Facility Name Friedman Place

Report Period Beginning: 070117 Ending: 063018

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>3,650</u>	2
3		Other			3
4	81	TOTALS	81	30,660	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>24,453</u>	<u>1,736</u>		<u>26,189</u>	5
6	Double Unit	<u>3,232</u>	<u>365</u>		<u>3,597</u>	6
7	Other					7
8	TOTALS	27,685	2,101		29,786	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified
bed days on line 4, column 4.) 97.15%

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

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.)

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 ☒ NO

Tax Year: 2017 Fiscal Year: 2018

* 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. _____

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	378,631	280,696	800	660,127	(619)	659,508	1
2	Housekeeping, Laundry and Maintenance	134,719	58,994	212,429	406,142		406,142	2
3	Heat and Other Utilities			129,117	129,117		129,117	3
4	Other (specify):			25,402	25,402		25,402	4
5	TOTAL General Services	513,350	339,689	367,749	1,220,788	(619)	1,220,169	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	568,904	18,962	18,469	606,335		606,335	6
7	Activities and Social Services	312,407		45,122	357,529		357,529	7
8	Other (specify):			619	619		619	8
9	TOTAL Health Care and Programs	881,310	18,962	64,209	964,482		964,482	9
	C. General Administration							
10	Administrative and Clerical	444,031	16,250	50,119	510,400		510,400	10
11	Marketing Materials, Promotions and Advertising			21,714	21,714		21,714	11
12	Employee Benefits and Payroll Taxes	503,552			503,552		503,552	12
13	Insurance-Property, Liability and Malpractice			54,184	54,184		54,184	13
14	Other (specify): telephone			16,375	16,375		16,375	14
15	TOTAL General Administration	947,583	16,250	142,392	1,106,225		1,106,225	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	2,342,244	374,901	574,350	3,291,495	(619)	3,290,876	16
	Capital Expenses							
	D. Ownership							
17	Depreciation				290,119		290,119	17
18	Interest				119,000		119,000	18
19	Real Estate Taxes				815		815	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership				409,934		409,934	23
24	GRAND TOTAL (Sum of lines 16 and 23)	2,342,244	374,901	574,350	3,701,429	(619)	3,700,810	24

Facility Name: Friedman Place

Report Period Beginning 070117 Ending: 063018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 34.35	1
2	Licensed Practical Nurses	2	26.89	2
3	Certified Nurse Assistants	12	14.03	3
4	Activity Director & Assistants	3	16.93	4
5	Social Service Workers	3	29.42	5
6	Head Cook	1	21.73	6
7	Cook Helpers/Assistants	12	13.39	7
8	Dishwashers			8
9	Maintenance Workers	1	17.97	9
10	Housekeepers	4	12.46	10
11	Laundry			11
12	Managers	3	44.14	12
13	Other Administrative	4	14.60	13
14	Clerical			14
15	Marketing			15
16	Other	1	29.22	16
17	Total (lines 1 thru 16)	47	\$	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:

070117

Ending:

063018

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	\$ 149,076	28	\$ 149,091	\$	1,994,117	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	various years purchases #2				2,037,367	74,079	28	74,086	7	982,163	6
7	building improvements				810,814	30,712	28	29,484	(1,228)	2,069,442	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)				\$ 6,948,181	\$ 253,867		\$ 252,661	\$ (1,221)	\$ 3,051,605	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	\$ 36,252			5	\$ 242,892	18
19	Vehicles	36,361				5	36,361	19
20	TOTAL (lines 18 and 19)	\$ 358,107	\$ 36,252				\$ 279,253	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

Report Period Beginning: 070117

Ending: 063018

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	\$ 119,000	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 1,700,000	\$ 1,700,000			\$ 119,000	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 1,700,000	\$ 1,700,000			\$ 119,000	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

Facility Name: Friedman Place

Report Period Beginning: 070117

Ending:

Page 7

063018

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 063018

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 268,759	\$	1
2	Cash-Patient Deposits	14,496		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	388,220		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,692		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)	\$ 674,167	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	404,278		12
13	Land	1,028,500		13
14	Buildings, at Historical Cost	4,100,000		14
15	Leasehold Improvements, at Historical Cost	2,832,141		15
16	Equipment, at Historical Cost	345,647		16
17	Accumulated Depreciation (book methods)	(3,332,673)		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)	\$ 5,377,893	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,052,060	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 46,163	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,175		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,928		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)	\$ 144,266	\$	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)	\$ 2,219,266	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,219,266	\$	47

*(See instructions.)

Facility Name: Friedman Place

Report Period Beginning: 070117

Ending:

063018

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	\$ 3,030,990	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,030,990	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	685,410	12
13	Interest and Other Investment Income	4,626	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 690,036	14
	D. Other Revenue (specify):		
15	cell tower	28,238	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 28,238	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,749,264	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,220,169	19
20	Health Care/ Personal Care	964,482	20
21	General Administration	1,106,225	21
	B. Capital Expense		
22	Ownership	409,934	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)	\$ 3,700,810	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 48,454	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 48,454	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