

		FOR BHF USE			

LL2

Supportive Living Facility

2019

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE & FAMILY SERVICES

COST REPORT FOR

SUPPORTIVE LIVING FACILITIES

(FISCAL YEAR 2019)

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 # # 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 070118 to 063019 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.

2019

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

(Title) Director of Finance and Operations

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

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>24,762</u>	<u>1,635</u>		<u>26,397</u>	5
6	Double Unit	<u>3,193</u>	<u>165</u>		<u>3,358</u>	6
7	Other					7
8	TOTALS	27,955	1,800		29,755	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.05%

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

70118

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 2018 Fiscal Year: 2019

* 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	411,593	287,784	1,700	701,077	(704)	700,373	1
2	Housekeeping, Laundry and Maintenance	152,779	36,884	123,132	312,795		312,795	2
3	Heat and Other Utilities			149,680	149,680		149,680	3
4	Other (specify):			28,445	28,445		28,445	4
5	TOTAL General Services	564,372	324,668	302,957	1,191,997	(704)	1,191,293	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	569,087	17,467	12,483	599,037		599,037	6
7	Activities and Social Services	328,025		40,877	368,902		368,902	7
8	Other (specify):			704	704		704	8
9	TOTAL Health Care and Programs	897,112	17,467	54,064	968,643		968,643	9
	C. General Administration							
10	Administrative and Clerical	462,809	9,485	62,296	534,590		534,590	10
11	Marketing Materials, Promotions and Advertising			15,314	15,314		15,314	11
12	Employee Benefits and Payroll Taxes	532,439			532,439		532,439	12
13	Insurance-Property, Liability and Malpractice			39,021	39,021		39,021	13
14	Other (specify): telephone			17,575	17,575		17,575	14
15	TOTAL General Administration	995,248	9,485	134,206	1,138,939		1,138,939	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	2,456,732	351,620	491,227	3,299,579	(704)	3,298,875	16
	Capital Expenses							
	D. Ownership							
17	Depreciation				297,684		297,684	17
18	Interest				119,000		119,000	18
19	Real Estate Taxes				306		306	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership				416,990		416,990	23
24	GRAND TOTAL (Sum of lines 16 and 23)	2,456,732	351,620	491,227	3,716,569	(704)	3,715,865	24

Facility Name: Friedman Place

Report Per 2019 070118 Ending: 063019

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 36.21	1
2	Licensed Practical Nurses	2	28.18	2
3	Certified Nurse Assistants	11	15.27	3
4	Activity Director & Assistants	3	17.31	4
5	Social Service Workers	3	28.30	5
6	Head Cook	1	23.56	6
7	Cook Helpers/Assistants	14	14.82	7
8	Dishwashers			8
9	Maintenance Workers	1	18.00	9
10	Housekeepers	4	13.12	10
11	Laundry			11
12	Managers	3	46.26	12
13	Other Administrative	4	16.88	13
14	Clerical			14
15	Marketing			15
16	Other	2	26.91	16
17	Total (lines 1 thru 16)	49	\$	17

VII. RELATED ORGANIZATIONS ##### ##

A. Enter below the names of all relat 3193 ##

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2

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

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

Facility Name: Friedman Place

2019

070118

Ending:

063019

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	\$	\$ 2,143,234	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)	1,056,262	6
7	building improvements				814,914	30,129	28	29,633	(496)	2,025,472 #	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				\$ 6,952,281	\$ 253,345		\$ 252,810	\$ (509)	\$ 3,081,734	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	\$ 328,441	\$ 32,463	\$		5	\$ 275,355	18
19	Vehicles	96,642	12,056			5	48,417	19
20	TOTAL (lines 18 and 19)	\$ 425,083	\$ 44,519	\$	\$		\$ 323,772	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

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	2018 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.

Facility Name: Friedman Place

Report Period Beginning: 070118

Ending:

063019

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 063019

2019

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 236,472	\$	1
2	Cash-Patient Deposits	21,225		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	421,832		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,693		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)	\$ 682,222	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	423,268		12
13	Land	1,028,500		13
14	Buildings, at Historical Cost	4,100,000		14
15	Leasehold Improvements, at Historical Cost	2,836,241		15
16	Equipment, at Historical Cost	412,623		16
17	Accumulated Depreciation (book method	(3,630,582)		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)	\$ 5,170,050	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,852,272	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 26,779	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,036		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,047		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)	\$ 149,862	\$	###
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,925,000		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)	\$ 1,925,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,074,862	\$	45
46	TOTAL EQUITY	\$ 3,777,410	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,852,272	\$	47

*(See instructions.)

Facility Name: Friedman Place

Report Period Beginning: 070118

Ending:

063019

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	\$ 3,246,666	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,246,666	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	349,985	12
13	Interest and Other Investment Income	22,275	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 372,260	14
	D. Other Revenue (specify):		
15	cell tower	42,302	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 42,302	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 3,661,228	18

		2	
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,191,293	19
20	Health Care/ Personal Care	968,643	20
21	General Administration	1,138,939	21
	B. Capital Expense		
22	Ownership	416,990	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)	\$ 3,715,865	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (54,637)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (54,637)	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

1635
165