

		FOR BHF USE			

LL2

Supportive Living Facility

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2020)

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: <u>1000052</u> Facility Name: <u>Friedman Place</u> Address: <u>5527 North Maplewood</u> <u>Chicago</u> <u>60625</u> Number City Zip Code County: <u>Cook</u> Telephone Number: (<u>773</u>) <u>989-9800</u> Fax # <u>773</u> <u>989-4889</u> Federal Employer ID Number: _____ Date Current Owners # # <u>10-07-05</u> # # Type of Ownership: <table style="width: 100%; margin-top: 10px;"><tr><td style="width: 33%;">☐ VOLUNTARY, NON-PROFIT</td><td style="width: 33%;">☐ PROPRIETARY</td><td style="width: 33%;">☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td></td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td></td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table> IRS Exemption Code _____ In the event there are further questions about this report, please contact: Name: <u>Rita Scaletta</u> Telephone Number: (<u>773</u>) <u>989-9800</u> Email Address: _____	☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County		☒ Corporation	☐ Other _____		☐ "Sub-S" Corp.			☐ Limited Liability Co.			☐ Trust			☐ Other _____		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2019</u> to <u>06/30/2020</u> 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) <u>Rita Scaletta</u> (Title) <u>Director of Finance and Operations</u> 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
☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
☒ Charitable Corp.	☐ Individual	☐ State																							
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	☐ Other _____																								

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>25,275</u>	<u>1,320</u>		<u>26,595</u>	5
6	Double Unit	<u>3,377</u>			<u>3,377</u>	6
7	Other					7
8	TOTALS	28,652	1,320		29,972	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.76%

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

967 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 3 (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: 2019 Fiscal Year: 2020

* 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. _____

STATE OF ILLINOIS

Page 3

Facility Name: Friedman Place

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

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	449,165	333,914	1,100	784,179	(977)	783,202	1
2	Housekeeping, Laundry and Maintenance	172,164	36,557	103,586	312,307		312,307	2
3	Heat and Other Utilities			153,934	153,934		153,934	3
4	Other (specify):			28,354	28,354		28,354	4
5	TOTAL General Services	621,329	370,471	286,974	1,278,774	(977)	1,277,797	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	585,860	23,373	12,005	621,238		621,238	6
7	Activities and Social Services	343,851		35,998	379,849		379,849	7
8	Other (specify):			977	977		977	8
9	TOTAL Health Care and Programs	929,711	23,373	48,980	1,002,064		1,002,064	9
	C. General Administration							
10	Administrative and Clerical	492,636	9,965	50,177	552,778		552,778	10
11	Marketing Materials, Promotions and Advertising			11,861	11,861		11,861	11
12	Employee Benefits and Payroll Taxes	734,048			734,048		734,048	12
13	Insurance-Property, Liability and Malpractice			40,425	40,425		40,425	13
14	Other (specify): telephone			19,016	19,016		19,016	14
15	TOTAL General Administration	1,226,684	9,965	121,479	1,358,128		1,358,128	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	2,777,724	403,809	457,433	3,638,966	(977)	3,637,989	16
	Capital Expenses							
	D. Ownership							
17	Depreciation				299,623		299,623	17
18	Interest				119,000		119,000	18
19	Real Estate Taxes				553		553	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership				419,176		419,176	23
24	GRAND TOTAL (Sum of lines 16 and 23)	2,777,724	403,809	457,433	4,058,142	(977)	4,057,165	24

Facility Name: Friedman Place

Report Per 2020 07/01/2019 Ending: 06/30/2020

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 33.41	1
2	Licensed Practical Nurses	1	30.68	2
3	Certified Nurse Assistants	12	15.71	3
4	Activity Director & Assistants	2	18.26	4
5	Social Service Workers	2	28.96	5
6	Head Cook	1	24.68	6
7	Cook Helpers/Assistants	12	15.25	7
8	Dishwashers			8
9	Maintenance Workers	1	18.76	9
10	Housekeepers	3	13.83	10
11	Laundry			11
12	Managers	3	47.57	12
13	Other Administrative	3	21.23	13
14	Clerical			14
15	Marketing			15
16	Other	1	36.24	16
17	Total (lines 1 thru 16)	44	\$	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

2020

07/01/2019

Ending:

06/30/2020

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	\$	2,292,310	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)	1,130,341	6
7	building improvements				835,781	30,138	28	30,392	254	135,612 #	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)				\$ 6,973,148	\$ 253,313		\$ 253,569	\$ 241	\$ 3,558,263	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	\$ 27,020	\$		5	\$ 302,375	18
19	Vehicles	96,642	19,290			5	67,707	19
20	TOTAL (lines 18 and 19)	\$ 425,083	\$ 46,310	\$	\$		\$ 370,082	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 Year Constructed	2 Number of Units	3 Date of Lease	4 Rental Amount	5 Total Yrs. of Lease	6 Total Years Renewal Option*		8. Is movable equipment rental included in building rental? ☐ YES ☐ NO
3	Original Building			/ /	\$			3	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.
4	Additions			/ /				4	
5				/ /				5	
6				/ /				6	
7	TOTAL				\$			7	

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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 396,222	\$	1
2	Cash-Patient Deposits	57,014		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	443,887		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)	\$ 897,123	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	534,896		12
13	Land	1,028,500		13
14	Buildings, at Historical Cost	4,100,000		14
15	Leasehold Improvements, at Historical Cost	2,857,105		15
16	Equipment, at Historical Cost	412,623		16
17	Accumulated Depreciation (book method:	(3,930,205)		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)	\$ 5,002,919	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,900,042	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 44,585	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	57,575		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	145,315		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)	\$ 247,475	# \$	###
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,887,500		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)	\$ 1,887,500	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,134,975	\$	45
46	TOTAL EQUITY	\$ 3,765,068	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 5,900,043	\$	47

*(See instructions.)

Facility Name: Friedman Place

Report Period Beginning: 07/01/2019

Ending:

06/30/2020

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	\$ 3,705,921	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,705,921	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	198,381	12
13	Interest and Other Investment Income	114,056	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 312,437	14
	D. Other Revenue (specify):		
15	cell tower	27,661	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 27,661	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,046,019	18

2			
	II. Expenses	Amount	
	A. Operating Expenses		
19	General Services	1,277,797	19
20	Health Care/ Personal Care	1,002,064	20
21	General Administration	1,358,128	21
	B. Capital Expense		
22	Ownership	419,176	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)	\$ 4,057,165	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ (11,146)	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ (11,146)	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