

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2007  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2007)**

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.

<p><b>I. Facility ID Number:</b> 1000052</p> <p><b>Facility Name:</b> <u>Friedman Place</u></p> <p><b>Address:</b> <u>5527 N. Maplewood</u> <u>Chicago</u> <u>60625</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> ( <u>773</u> ) <u>989-9800</u> Fax # <u>773 989-4889</u></p> <p><b>Federal Employer ID Number:</b> <u>30-0246731</u></p> <p><b>Date Current Owners were Certified:</b> <u>October 7, 2005</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Rita Scaletta</u> <b>Telephone Number:</b> ( <u>773</u> ) <u>989-9800</u></p>	<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	<b>IRS Exemption Code</b> _____	<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 _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/06</u> to <u>06/30/07</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td style="width:20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ (Type or Print Name) <u>Ann Farnam Lagory</u> (Title) <u>Executive Director</u></td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____</td> </tr> <tr> <td></td> <td>(Date) _____</td> </tr> </table> <p align="right">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</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ (Type or Print Name) <u>Ann Farnam Lagory</u> (Title) <u>Executive Director</u>		(Date) _____	<b>Paid Preparer</b>	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( <u>    </u> ) _____ Fax # ( <u>    </u> ) _____		(Date) _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
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	(Date) _____																																

Facility Name Friedman Place

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

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	17,656	5,045		22,701	5
6	Double Unit	348			348	6
7	Other					7
8	TOTALS	18,004	5,045		23,049	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 77.96%

D. Indicate the number of paid bed-hold days the SLF had during this year       
 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 142 (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)

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H. ACCOUNTING BASIS

ACCURAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 2005 Fiscal Year: 2006

\* 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. TAX DONATION PROGRAM

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. GRANT

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. ENERGY GRANT

Facility Name: Friedman Place

Report Period Beginning:

07/01/06

Ending:

06/30/07

## 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			
<b>A. General Services</b>								
1	Dietary and Food Purchase	248,330	182,507	5,848	436,685		436,685	1
2	Housekeeping, Laundry and Maintenance	92,477	13,239	77,233	182,949		182,949	2
3	Heat and Other Utilities			131,644	131,644		131,644	3
4	Other (specify):			16,564	16,564		16,564	4
5	<b>TOTAL General Services</b>	<b>340,807</b>	<b>195,746</b>	<b>231,289</b>	<b>767,842</b>		<b>767,842</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	463,509	19,409	3,993	486,912		486,912	6
7	Activities and Social Services	111,320	10,244	51,907	173,471		173,471	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>574,829</b>	<b>29,653</b>	<b>55,900</b>	<b>660,383</b>		<b>660,383</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	277,885	48,102	74,266	400,252		400,252	10
11	Marketing Materials, Promotions and Advertising	45,000	18,933	15,242	79,174		79,174	11
12	Employee Benefits and Payroll Taxes			250,033	250,033		250,033	12
13	Insurance-Property, Liability and Malpractice			43,725	43,725		43,725	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>322,885</b>	<b>67,034</b>	<b>383,265</b>	<b>773,184</b>		<b>773,184</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,238,521</b>	<b>292,433</b>	<b>670,454</b>	<b>2,201,409</b>		<b>2,201,409</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			228,079	228,079		228,079	17
18	Interest			47,324	47,324	119,000	166,324	18
19	Real Estate Taxes							19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>			<b>275,403</b>	<b>275,403</b>	<b>119,000</b>	<b>394,403</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,238,521</b>	<b>292,433</b>	<b>945,857</b>	<b>2,476,812</b>	<b>119,000</b>	<b>2,595,811</b>	<b>24</b>

Facility Name: Friedman Place

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

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3	\$ 20.90	1
2	Licensed Practical Nurses	4	21.53	2
3	Certified Nurse Assistants	16	9.33	3
4	Activity Director & Assistants	5	16.43	4
5	Social Service Workers	1	25.37	5
6	Head Cook	1	20.40	6
7	Cook Helpers/Assistants	10	10.70	7
8	Dishwashers			8
9	Maintenance Workers	1	16.87	9
10	Housekeepers	4	10.03	10
11	Laundry			11
12	Managers	3	23.68	12
13	Other Administrative	1	37.50	13
14	Clerical	4	10.33	14
15	Marketing	1	21.01	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>54</b>	<b>\$ 14.09</b>	<b>17</b>

**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
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$ 3</b>

**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 <u>1</u>	City <u>2</u>
_____	_____
_____	_____
_____	_____

OTHER RELATED BUSINESS ENTITIES		
Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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).

Facility Name: Friedman Place

Report Period Beginning:

07/01/06

Ending:

06/30/07

## 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	\$ 212,571	28	\$ 213,558	\$ 987	\$ 291,930	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		Deaf/Blind Rooms			4,822	175	28	175			6
7		Chiller			7,400	269	28	269			7
8		Kitchen Ducts			2,983	108	28	108			8
9		Elevator			4,441	149	28	149			9
10		Laundry Room			9,403	243	28	243			10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 5,874,764	\$ 213,515		\$ 214,502	\$ 987	\$ 291,930	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	\$ 45,991	\$ 13,407	\$	13,361	5	\$ 23,835	18
19	Vehicles	24,604	1,157		1,157	5	20,049	19
20	TOTAL (lines 18 and 19)	\$ 70,595	\$ 14,564	\$	14,518		\$ 43,884	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: 07/01/06

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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	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	<b>TOTAL</b>			\$			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				
		YES	NO			Original	Balance				
	<b>A. Directly Facility Related Long-Term</b>										
1	KAGAN HOME	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
	<b>Working Capital</b>										
4	MB Financial Bank		x	TO COVER OPERATING EXPENSES	10/01/06	593,242	520,642	10/01/16	8.2500	47,324	4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 2,293,242	\$ 2,220,642			\$ 166,324	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 2,293,242	\$ 2,220,642			\$ 166,324	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: 07/01/06

Ending:

06/30/07

06/30/07

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 17,079	\$	1
2	Cash-Patient Deposits	17,042		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	320,489		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,906		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 367,515	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,000,000		13
14	Buildings, at Historical Cost	5,845,715		14
15	Leasehold Improvements, at Historical Cost	29,049		15
16	Equipment, at Historical Cost	70,595		16
17	Accumulated Depreciation (book methods)	(561,416)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 6,383,943	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,751,458	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 35,464	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,042		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,749		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 58,254	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	1,538,307		38
39	Mortgage Payable	1,700,000		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 3,238,307	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 3,296,561	\$	45
46	<b>TOTAL EQUITY</b>	\$	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 3,296,561	\$	47

\*(See instructions.)

Facility Name: Friedman Place

Report Period Beginning: 07/01/06

Ending:

06/30/07

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

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 2,010,950	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 2,010,950	3
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants	292,413	6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 292,413	11
<b>C. Non-Operating Revenue</b>			
12	Contributions	144,252	12
13	Interest and Other Investment Income	421	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 144,673	14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 2,448,036	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	767,842	19
20	Health Care/ Personal Care	660,383	20
21	General Administration	773,184	21
<b>B. Capital Expense</b>			
22	Ownership	394,403	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 2,595,811	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ (147,775)	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ (147,775)	31