

Facility Name Friedman Place

Report Period Beginning

Ending: 63008

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	26,048	1
2	7	Double Unit Apartment	7	1,408	2
3		Other			3
4	81	TOTALS	81	27,456	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	20,109	5,260		25,369	5
6	Double Unit	349			349	6
7	Other					7
8	TOTALS	20,458	5,260		25,718	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 93.67%

D. Indicate the number of paid bed-hold days the SLF had during this year
0 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 226 (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: 2009 Fiscal Year: 2008

* 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. _____

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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	277,364	217,787	8,410	503,561		503,561	1
2	Housekeeping, Laundry and Maintenance	102,777	12,844	79,091	194,712		194,712	2
3	Heat and Other Utilities			161,365	161,365		161,365	3
4	Other (specify): scavenger,pest,landscaping			28,521	28,521	64,418	92,939	4
5	TOTAL General Services	380,141	230,631	277,387	888,159	64,418	952,577	5
B. Health Care and Programs								
6	Health Care/ Personal Care	476,432	17,396	38,063	531,891		531,891	6
7	Activities and Social Services	173,459		85,308	258,767		258,767	7
8	Other (specify): Dental Services			6,849	6,849		6,849	8
9	TOTAL Health Care and Programs	649,891	17,396	130,220	797,507		797,507	9
C. General Administration								
10	Administrative and Clerical	330,840	30,266	21,443	382,549		382,549	10
11	Marketing Materials, Promotions and Advertising	52,520	20,448	17,903	90,871		90,871	11
12	Employee Benefits and Payroll Taxes	304,281			304,281		304,281	12
13	Insurance-Property, Liability and Malpractice	37,591			37,591		37,591	13
14	Other (specify): Telephone			23,690	23,690		23,690	14
15	TOTAL General Administration	725,232	50,714	63,036	838,982		838,982	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	1,755,264	298,741	470,643	2,524,648	64,418	2,589,066	16
Capital Expenses								
D. Ownership								
17	Depreciation			230,991	230,991		230,991	17
18	Interest			34,929	34,929	122,893	157,822	18
19	Real Estate Taxes			1,500	1,500		1,500	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			267,420	267,420	122,893	390,313	23
24	GRAND TOTAL (Sum of lines 16 and 23)	1,755,264	298,741	738,063	2,792,068	187,311	2,979,379	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	1	\$ 35.00	1
2	Licensed Practical Nurses	1	24.00	2
3	Certified Nurse Assistants	11	10.84	3
4	Activity Director & Assistants	4	16.00	4
5	Social Service Workers			5
6	Head Cook	1	23.38	6
7	Cook Helpers/Assistants	8	11.28	7
8	Dishwashers			8
9	Maintenance Workers	1	20.16	9
10	Housekeepers	3	11.16	10
11	Laundry			11
12	Managers	6	26.24	12
13	Other Administrative	1	11.00	13
14	Clerical			14
15	Marketing	1	25.25	15
16	Other			16
17	Total (lines 1 thru 16)	38	\$ 15.21	17

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

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).

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VIII. OWNERSHIP COSTSA. 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	\$ 212,571	\$	\$ 717,451	1
2											2
3											3
4											4
5											5
Improvement Type											
6		Deaf/Blind Rooms			4,822	175	28	175		446	6
7		Chiller			7,400	269	28	269		549	7
8		Kitchen Ducts			2,983	108	28	108		285	8
9		Elevator			4,441	162	28	162		311	9
10		Laundry Room			9,403	342	28	342		584	10
11		Water pump			6,010	219	28	219		209	11
12		Gemini Computers			1,924	70	28	70		67	12
13		Chillers			3,510	128	28	128		122	13
14		Plumbing			8,250	300	28	300		288	14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 5,894,458	\$ 214,344		\$ 214,344	\$	\$ 720,312	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	\$ 1,125,002	\$ 10,874	\$		5	\$ 51,698	18
19	Vehicles	24,604	256			5	24,348	19
20	TOTAL (lines 18 and 19)	\$ 1,149,606	\$ 11,130	\$			\$ 76,046	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	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	Interest Rate (4 Digits)	Reporting Period Int. Expense
		YES	NO			Original	Balance			
	A. Directly Facility Related Long-Term									
1	KAGAN HOME	X		TO PURCHASE BUILDING	03/03/05	\$ 1,700,000	\$ 1,700,000	03/31/35	7.0000	\$ 119,000
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4	MB Financial Bank		x	TO COVER OPERATING EXPENSES	10/01/06	593,242	432,867	10/01/16	6.0000	34,929
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 2,293,242	\$ 2,132,867			\$ 153,929
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 2,293,242	\$ 2,132,867			\$ 153,929

* 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 063008

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 94,277	\$	1
2	Cash-Patient Deposits	31,678		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	272,335		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,868		6
7	Other Prepaid Expenses	7,140		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 411,298	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,000,000		13
14	Buildings, at Historical Cost	4,100,000		14
15	Leasehold Improvements, at Historical Cost	1,794,459		15
16	Equipment, at Historical Cost	100,864		16
17	Accumulated Depreciation (book methods)	(796,368)		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)	\$ 6,198,955	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,610,253	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 18,008	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	31,678		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	23,819		30
31	Accrued Taxes Payable	1,076		31
32	Accrued Interest Payable	122,893		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)	\$ 197,474	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable	1,182,867		38
39	Mortgage Payable	1,700,000		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)	\$ 2,882,867	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 3,080,341	\$	45
46	TOTAL EQUITY	\$ 3,529,912	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,610,253	\$	47

*(See instructions.)

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

		1	
Revenue		Amount	
A. SLF Resident Care			
1	Gross SLF Resident Revenue	\$ 2,371,650	1
2	Discounts and Allowances		2
SUBTOTAL Resident Care			
3	(line 1 minus line 2)	\$ 2,371,650	3
B. Other Operating Revenue			
4	Special Services	3,395	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
SUBTOTAL OTHER OPERATING REVENUE			
11	(sum of lines 4 thru 10)	\$ 3,395	11
C. Non-Operating Revenue			
12	Contributions	386,731	12
13	Interest and Other Investment Income		13
SUBTOTAL Non-Operating Revenue			
14	(sum of lines 12 and 13)	\$ 386,731	14
D. Other Revenue (specify):			
15			15
16			16
SUBTOTAL Other Revenue			
17	(sum of lines 15 and 16)	\$	17
TOTAL REVENUE			
18	(sum of lines 3, 11, 14 and 17)	\$ 2,761,776	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	952,577	19
20	Health Care/ Personal Care	797,507	20
21	General Administration	838,982	21
B. Capital Expense			
22	Ownership	390,313	22
C. Other Expenses			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
TOTAL EXPENSES			
28	(sum of lines 19 thru 27)	\$ 2,979,379	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ (217,603)	29
Income Taxes			
30		\$	30
NET INCOME OR LOSS FOR THE YEAR			
31	(line 29 minus line 30)	\$ (217,603)	31