FOR BHF USE

LL2

Supportive Living Facility

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2009)

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 Name: Friedman Place

Address: 5527 North Maplewood (Number) Chicago (City) 60625 (Zip Code)

County: cook

Telephone Number: (773) 989-9800 **Fax #** 773 989-4889

Federal Employer ID Number: 30-0246731

Date Current Owners were Certified: 10-07-05

Type of Ownership:

	VOLUNTARY, NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rita Scaletta **Telephone Number:** (773 989-9800
Email Address: rita@friedmanplace.org

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 070108 to 063009 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) Ann Lagory
(Title) Executive Director

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**

Facility Name Friedman Place Report Period Beginning: 070108 Ending: 063009

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days
Date of change in certified units / /

	1 Units at Beginning of Report Period	2 Type of Apartment	3 Units at End of Report Period	4 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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	19,490	4,910		24,400	5
6	Double Unit	1,813	730		2,543	6
7	Other					7
8	TOTALS	21,303	5,640		26,943	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 91.13%

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.** 164 **(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 [x]

F. Does the BALANCE SHEET reflect any non-SLF assets?
YES [ ] NO [x]

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*
[x]	[ ]	[ ]

I. Is your fiscal year identical to your tax year? [ ] YES [x] NO
Tax Year: 2008 Fiscal Year: ###
* 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.

Facility Name: Friedman Place **Report Period Beginning: 070108 Ending: 063009**

IV. COST CENTER EXPENSES (please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage	Supplies	Other	Total			
	A. General Services	1	2	3	4	5	6	
1	Dietary and Food Purchase	312,054	217,228	13,936	543,218		543,218	1
2	Housekeeping, Laundry and Maintenance	104,731	10,667	96,961	212,359		212,359	2
3	Heat and Other Utilities			184,781	184,781		184,781	3
4	Other (specify):scavenger, pest control, landscaping			30,760	30,760	76,587	107,347	4
5	**TOTAL General Services**	416,785	227,895	326,438	971,118	76,587	1,047,705	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	583,475	12,697	39,295	635,467		635,467	6
7	Activities and Social Services	239,072		85,113	324,185		324,185	7
8	Other (specify): Dental			4,219	4,219		4,219	8
9	**TOTAL Health Care and Programs**	822,547	12,697	128,627	963,871		963,871	9
	C. General Administration							
10	Administrative and Clerical	349,263	19,161	54,967	423,391		423,391	10
11	Marketing Materials, Promotions and Advertising		23,986	23,986	47,971		47,971	11
12	Employee Benefits and Payroll Taxes	147,418		174043	321,461		321,461	12
13	Insurance-Property, Liability and Malpractice			34,458	34,458		34,458	13
14	Other (specify): Telephone			19,728	19,728		19,728	14
15	**TOTAL General Administration**	496,681	43,147	307,182	847,009		847,009	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	1,736,013	283,739	762,247	2,781,998	76,587	2,858,585	16
	Capital Expenses							
	D. Ownership							
17	Depreciation				230,657		230,657	17
18	Interest				16,898		16,898	18
19	Real Estate Taxes				789		789	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**				248,344		248,344	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	1,736,013	283,739	762,247	3,030,342	76,587	3,106,929	24

Facility Name: Friedman Place **Report Period Beginning 070108 Ending: 063009**

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	13	11.26	3
4	Activity Director & Assistants	4	15.60	4
5	Social Service Workers			5
6	Head Cook	1	23.39	6
7	Cook Helpers/Assistants	8	11.03	7
8	Dishwashers			8
9	Maintenance Workers	1	18.20	9
10	Housekeepers	4	10.63	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)**	41	$ 15.46	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				OTHER RELATED BUSINESS ENTITIES					
Name	1	City	2	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).

Facility Name: Friedman Place **Report Period Beginning: 070108** **Ending: 063009**

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	$ 214,118	28	$ 212,571	$	$ 930,022	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	Deaf/Blind Rooms				4,822	175	28	175		621	6
7	Chiller				7,400	269	28	269		818	7
8	Kitchen Ducts				2,983	108	28	108		393	8
9	Elevator				4,441	162	28	162		473	9
10	Laundry Room				9,403	342	28	342		926	10
11	Water pump				6,010	219	28	219		428	11
12	Gemini Compuers				1,924	70	28	70		137	12
13	Chillers				17,080	580	28	580		702	13
14	Plumbing				8,250	300	28	300		588	14
15	Dog Run				3,800	127	28	127		127	15
16	Smoke Alarms				9,669	322	28	322		322	16
17	Roof				8,800	293	28	293		293	
17	TOTAL (lines 1 thru 16)				$ 5,930,297	$ 217,085		$ 215,245	$	$ 935,850	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	$ 90,714	$ 13,316	$		5	$ 65,024	18
19	Vehicles	24,604	256			5	24,604	19
20	TOTAL (lines 18 and 19)	$ 115,318	$ 13,572	$	$		$ 89,628	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: 070108 Ending: 063009

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 Name of Lender	2 Related** YES	2 Related** NO	3 Purpose of Loan	4 Date of Note	6 Amount of Note Original	6 Amount of Note Balance	7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
	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	$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4	MB Financial Bank		x	TO COVER OPERATING EXPENSES	10/01/06	593,242	384,632	10/01/16	3.2500	16,898	4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 2,293,242	$ 2,084,632			$ 16,898	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 2,293,242	$ 2,084,632			$ 16,898	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:** 070108 **Ending:** 063009

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 063009 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 209,472	$	1
2	Cash-Patient Deposits	23,280		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	247,289		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,856		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)**	$ 485,897	$	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	1,830,297		15
16	Equipment, at Historical Cost	115,319		16
17	Accumulated Depreciation (book methods)	(1,027,025)		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)**	$ 6,018,591	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,504,488	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 35,711	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,280		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	32,059		30
31	Accrued Taxes Payable	1,392		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)**	$ 92,442	$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable	1,134,632		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)**	$ 2,834,632	$	44
45	**TOTAL LIABILITIES (sum of lines 37 and 44)**	$ 2,927,074	$	45
46	**TOTAL EQUITY**	$	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 2,927,074	$	47

***(See instructions.)**

Facility Name: Friedman Place **Report Period Beginning: 070108 Ending: 063009**

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

	Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 2,591,341	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 2,591,341	3
	B. Other Operating Revenue		
4	Special Services	1,841	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)**	$ 1,841	11
	C. Non-Operating Revenue		
12	Contributions	435,661	12
13	Interest and Other Investment Income	610	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 436,271	14
	D. Other Revenue (specify):		
15			15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,029,453	18

	Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,047,705	19
20	Health Care/ Personal Care	963,871	20
21	General Administration	847,009	21
	B. Capital Expense		
22	Ownership	248,344	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)**	$ 3,106,929	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ (77,476)	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ (77,476)	31