

FOR BHF USE					

LL2

Supportive Living Facility

**2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2016)**

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>I. Facility ID Number: <u>1000052</u></p> <p>Facility Name: <u>Friedman Place</u></p> <p>Address: <u>5527 North Maplewood</u> <u>Chicago</u> <u>60625</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: (<u>773</u>) <u>989-9800</u> Fax # <u>773 989-4889</u></p> <p>Federal Employer ID Number: _____</p> <p>Date Current Owners were Certified: <u>10-07-05</u></p> <p>Type of Ownership:</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>IRS Exemption Code _____</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>In the event there are further questions about this report, please contact: Name: <u>Rita Scaletta</u> Telephone Number: (<u>773-989-9800</u>) Email Address: _____</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	IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/15</u> to <u>06/30/16</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 style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Rita Scaletta</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Director of Finance and Operations</u></td> <td></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td></td> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td></td> <td>(Telephone) (<u> </u>) _____</td> <td>Fax # (<u> </u>) _____</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>	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) (<u> </u>) _____	Fax # (<u> </u>) _____
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Facility Name: Friedman Place

Report Period Beginning:

07/01/15

Ending:

06/30/16

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	373,406	283,738	1,000	658,144	(3,949)	654,195	1
2	Housekeeping, Laundry and Maintenance	154,254	53,524	124,078	331,856		331,856	2
3	Heat and Other Utilities			201,305	201,305		201,305	3
4	Other (specify):scavenger, pest control, landscaping			22,216	22,216		22,216	4
5	TOTAL General Services	527,660	337,262	348,599	1,213,521	(3,949)	1,209,572	5
B. Health Care and Programs								
6	Health Care/ Personal Care	753,360	18,776	21,763	793,899		793,899	6
7	Activities and Social Services	181,648		49,788	231,436		231,436	7
8	Other (specify): Charity Care			3,949	3,949		3,949	8
9	TOTAL Health Care and Programs	935,008	18,776	75,500	1,029,284		1,029,284	9
C. General Administration								
10	Administrative and Clerical	439,152	14,427	81,666	535,245		535,245	10
11	Marketing Materials, Promotions and Advertising			33,694	33,694		33,694	11
12	Employee Benefits and Payroll Taxes	528,517			528,517		528,517	12
13	Insurance-Property, Liability and Malpractice			29,032	29,032		29,032	13
14	Other (specify): Telephone			16,716	16,716		16,716	14
15	TOTAL General Administration	967,669	14,427	161,108	1,143,204		1,143,204	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	2,430,337	370,465	585,207	3,386,009	(3,949)	3,382,060	16
Capital Expenses								
D. Ownership								
17	Depreciation				262,660		262,660	17
18	Interest				126,131		126,131	18
19	Real Estate Taxes				4,275		4,275	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership				393,066		393,066	23
24	GRAND TOTAL (Sum of lines 16 and 23)	2,430,337	370,465	585,207	3,779,075	(3,949)	3,775,126	24

Facility Name: Friedman Place

Report Period Beginning 07/01/15 Ending: 06/30/16

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	3	\$ 31.98	1
2	Licensed Practical Nurses	2	25.22	2
3	Certified Nurse Assistants	14	12.70	3
4	Activity Director & Assistants	3	25.33	4
5	Social Service Workers	1	30.49	5
6	Head Cook	1	20.19	6
7	Cook Helpers/Assistants	13	12.40	7
8	Dishwashers			8
9	Maintenance Workers	1	17.24	9
10	Housekeepers	4	11.61	10
11	Laundry			11
12	Managers	3	40.67	12
13	Other Administrative	4	15.88	13
14	Clerical			14
15	Marketing			15
16	Other Development	2	27.50	16
17	Total (lines 1 thru 16)	51	\$	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).

Facility Name: Friedman Place

Report Period Beginning:

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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		\$ 4,100,000	\$ 149,091	28	\$ 149,091	\$	\$ 1,695,924	1
2											2
3											3
4											4
5											5
Improvement Type											
6		various years purchases #5			2,037,367	74,086	28	72,763	(1,323)	833,895	6
7		building improvements			701,547	9,287	28	25,055	15,768	15,821	7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
	TOTAL (lines 1 thru 16)				\$ 6,838,914	\$ 232,464		\$ 246,909	\$ 14,445	\$ 2,545,640	

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	\$ 310,052	\$ 29,586	\$		5	\$ 169,301	18
19	Vehicles	36,361	610			5	35,446	19
20	TOTAL (lines 18 and 19)	\$ 346,413	\$ 30,196	\$	\$		\$ 204,747	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

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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	AJB	X		TO PURCHASE BUILDING	03/03/05	\$ 1,700,000	\$ 1,700,000	03/31/35	7.0000	\$ 122,893
2					/ /			/ /		
3					/ /			/ /		
	Working Capital									
4	AJB		x	TO COVER OPERATING EXPENSES	05/09/12	593,242	0	05/09/18	3.0000	3,238
5					/ /			/ /		
6					/ /			/ /		
7	TOTAL Facility Related					\$ 2,293,242	\$ 1,700,000			\$ 126,131
	B. Non-Facility Related									
8					/ /			/ /		
9					/ /			/ /		
10	TOTALS (lines 7, 8 and 9)					\$ 2,293,242	\$ 1,700,000			\$ 126,131

* 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

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XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/16

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 369,983	\$	1
2	Cash-Patient Deposits	15,585		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	265,223		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,028		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)	\$ 656,819	\$	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	2,738,914		15
16	Equipment, at Historical Cost	346,413		16
17	Accumulated Depreciation (book methods)	(2,750,387)		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)	\$ 5,434,940	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,091,759	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,504	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,507		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,915		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)	\$ 247,927	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,075,000		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)	\$ 2,075,000	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 2,322,927	\$	45
46	TOTAL EQUITY	\$ 3,768,832	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 6,091,759	\$	47

*(See instructions.)

Facility Name: Friedman Place

Report Period Beginning: 07/01/15

Ending:

06/30/16

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	\$ 3,158,977	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 3,158,977	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	971,763	12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 971,763	14
D. Other Revenue (specify):			
15	cell tower income	25,195	15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$ 25,195	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 4,155,935	18

		2	
Expenses		Amount	
A. Operating Expenses			
19	General Services	1,209,572	19
20	Health Care/ Personal Care	1,029,284	20
21	General Administration	1,143,204	21
B. Capital Expense			
22	Ownership	393,066	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)	\$ 3,775,126	28
Income Before Income Taxes			
29	(line 18 minus line 28)	\$ 380,810	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 380,810	31