

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2017  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2017)**

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> <u>1000052</u></p> <p><b>Facility Name:</b> <u>Friedman Place</u></p> <hr/> <p><b>Address:</b> <u>5527 North Maplewood</u> <u>Chicago</u> <u>60625</u></p> <p align="center">Number City Zip Code</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> _____</p> <p><b>Date Current Owners were Certified:</b> <u>10-07-05</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></p> <p><b>Name:</b> <u>Rita Scaletta</u> <b>Telephone Number:</b> ( <u>773</u> ) <u>989-9800</u></p> <p><b>Email Address:</b> _____</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>070116</u> to <u>063017</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%;"><b>Officer or Administrator of Provider</b></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><b>Paid Preparer</b></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 &amp; 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>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Rita Scaletta</u>			(Title) <u>Director of Finance and Operations</u>		<b>Paid Preparer</b>	(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: 070116 Ending: 063017

**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	3,650	2
3		Other			3
4	81	TOTALS	81	30,660	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 Resident Days by Unit and Primary Source of Payment			5	
		Medicaid Recipient	Private Pay	Other		
5	Single Unit	23,567	2,307		25,874	5
6	Double Unit	3,234	362		3,596	6
7	Other					7
8	TOTALS	26,801	2,669		29,470	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 96.12%

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

688 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 46 (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

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 2016 Fiscal Year: 2017

\* 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:

070116

Ending:

063017

## 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	359,153	282,628	1,500	643,281	(1,543)	641,738	1
2	Housekeeping, Laundry and Maintenance	142,088	30,891	132,031	305,011		305,011	2
3	Heat and Other Utilities			121,461	121,461		121,461	3
4	Other (specify):			17,725	17,725		17,725	4
5	<b>TOTAL General Services</b>	<b>501,241</b>	<b>313,519</b>	<b>272,717</b>	<b>1,087,477</b>	<b>(1,543)</b>	<b>1,085,935</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	587,339	16,188	17,989	621,515		621,515	6
7	Activities and Social Services	274,113		44,456	318,569		318,569	7
8	Other (specify):			1,543	1,543		1,543	8
9	<b>TOTAL Health Care and Programs</b>	<b>861,452</b>	<b>16,188</b>	<b>63,987</b>	<b>941,627</b>		<b>941,627</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	479,330	17,721	67,494	564,545		564,545	10
11	Marketing Materials, Promotions and Advertising			13,187	13,187		13,187	11
12	Employee Benefits and Payroll Taxes	481,284			481,284		481,284	12
13	Insurance-Property, Liability and Malpractice			37,408	37,408		37,408	13
14	Other (specify): telephone			16,375	16,375		16,375	14
15	<b>TOTAL General Administration</b>	<b>960,614</b>	<b>17,721</b>	<b>134,464</b>	<b>1,112,799</b>		<b>1,112,799</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>2,323,307</b>	<b>347,428</b>	<b>471,169</b>	<b>3,141,904</b>	<b>(1,543)</b>	<b>3,140,361</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation				291,115		291,115	17
18	Interest							18
19	Real Estate Taxes				472		472	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	<b>TOTAL Ownership</b>				<b>291,587</b>		<b>291,587</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>2,323,307</b>	<b>347,428</b>	<b>471,169</b>	<b>3,433,490</b>	<b>(1,543)</b>	<b>3,431,947</b>	<b>24</b>

Facility Name: Friedman Place

Report Period Beginning: 070116

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	\$ 32.86	1
2	Licensed Practical Nurses	2	25.94	2
3	Certified Nurse Assistants	11	13.69	3
4	Activity Director & Assistants	3	16.24	4
5	Social Service Workers	2	29.32	5
6	Head Cook	1	19.00	6
7	Cook Helpers/Assistants	14	12.68	7
8	Dishwashers			8
9	Maintenance Workers	1	17.38	9
10	Housekeepers	4	11.95	10
11	Laundry			11
12	Managers	3	52.55	12
13	Other Administrative	4	15.77	13
14	Clerical			14
15	Marketing			15
16	Other	2	23.40	16
17	<b>Total (lines 1 thru 16)</b>	<b>50</b>	<b>\$</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>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	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

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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	\$ 149,117	28	\$ 149,091	\$	\$ 1,845,041	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6		various years purchases #2			2,037,367	74,099	28	74,086	(13)	907,994	6
7		building improvements			795,937	29,138	28	28,943	(195)	44,959	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)				\$ 6,933,304	\$ 252,354		\$ 252,120	\$ (208)	\$ 2,797,994	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	\$ 321,746	\$ 37,846	\$		5	\$ 206,640	18
19	Vehicles	36,361	915			5	37,961	19
20	TOTAL (lines 18 and 19)	\$ 358,107	\$ 38,761	\$	\$		\$ 244,601	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: 070116

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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	Name of Lender	2		3	4	6		7	8	9	
			Related**				Purpose of Loan	Date of Note				
			YES	NO			Original	Balance				
		<b>A. Directly Facility Related</b>										
		<b>Long-Term</b>										
1		AJB	X		TO PURCHASE BUILDING	03/03/05	\$ 1,700,000	\$ 1,700,000	03/31/35	7.0000	\$ 122,893	1
2						/ /			/ /			2
3						/ /			/ /			3
		<b>Working Capital</b>										
4						/ /			/ /			4
5						/ /			/ /			5
6						/ /			/ /			6
7		<b>TOTAL Facility Related</b>					\$ 1,700,000	\$ 1,700,000			\$ 122,893	7
		<b>B. Non-Facility Related</b>										
8						/ /			/ /			8
9						/ /			/ /			9
10		<b>TOTALS (lines 7, 8 and 9)</b>					\$ 1,700,000	\$ 1,700,000			\$ 122,893	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: 070116

Ending:

063017

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 063017

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 47,228	\$	1
2	Cash-Patient Deposits	9,796		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	732,599		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):	1,028		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 796,679	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,028,500		13
14	Buildings, at Historical Cost	4,388,639		14
15	Leasehold Improvements, at Historical Cost	2,517,802		15
16	Equipment, at Historical Cost	345,648		16
17	Accumulated Depreciation (book methods)	(3,042,599)		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>	\$ 5,237,991	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,034,670	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 66,616	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	9,596		28
29	Short-Term Notes Payable	414		29
30	Accrued Salaries Payable	64,131		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>	\$ 140,756	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable			38
39	Mortgage Payable	2,075,000		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>	\$ 2,075,000	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 2,215,756	\$	45
46	<b>TOTAL EQUITY</b>	\$	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 2,215,756	\$	47

\*(See instructions.)

Facility Name: Friedman Place

Report Period Beginning: 070116

Ending:

063017

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

		1	
I. Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 3,084,039	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care (line 1 minus line 2)</b>	<b>\$ 3,084,039</b>	<b>3</b>
<b>B. Other Operating Revenue</b>			
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	<b>SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)</b>	<b>\$</b>	<b>11</b>
<b>C. Non-Operating Revenue</b>			
12	Contributions	496,533	12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)</b>	<b>\$ 496,533</b>	<b>14</b>
<b>D. Other Revenue (specify):</b>			
15	cell tower	25,895	15
16			16
17	<b>SUBTOTAL Other Revenue (sum of lines 15 and 16)</b>	<b>\$ 25,895</b>	<b>17</b>
18	<b>TOTAL REVENUE (sum of lines 3, 11, 14 and 17)</b>	<b>\$ 3,606,467</b>	<b>18</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	1,085,935	19
20	Health Care/ Personal Care	941,627	20
21	General Administration	1,112,799	21
<b>B. Capital Expense</b>			
22	Ownership	414,480	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):	1,543	25
26			26
27			27
28	<b>TOTAL EXPENSES (sum of lines 19 thru 27)</b>	<b>\$ 3,556,383</b>	<b>28</b>
29	<b>Income Before Income Taxes (line 18 minus line 28)</b>	<b>\$ 50,084</b>	<b>29</b>
30	<b>Income Taxes</b>	<b>\$</b>	<b>30</b>
31	<b>NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)</b>	<b>\$ 50,084</b>	<b>31</b>
<b>III. Net Resident Care Revenue detailed by Payer Source</b>			
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	<b>TOTAL (This total must agree to Line 3)</b>	<b>\$</b>	<b>37</b>