FOR BHF USE

LL2

Supportive Living Facility

2018
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.

I. Facility ID Number: 1000052

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:

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:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 070117 to 063018 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) Rita Scaletta
(Title) Director of Finance and Operations

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: 070117 Ending: 063018

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	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 Resident Days by Unit and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
5	Single Unit	24,453	1,736		26,189	5
6	Double Unit	3,232	365		3,597	6
7	Other					7
8	TOTALS	27,685	2,101		29,786	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 97.15%

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 [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: 2017 Fiscal Year: 2018
* 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: 070117 Ending: 063018**

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	378,631	280,696	800	660,127	(619)	659,508	1
2	Housekeeping, Laundry and Maintenance	134,719	58,994	212,429	406,142		406,142	2
3	Heat and Other Utilities			129,117	129,117		129,117	3
4	Other (specify):			25,402	25,402		25,402	4
5	**TOTAL General Services**	513,350	339,689	367,749	1,220,788	(619)	1,220,169	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	568,904	18,962	18,469	606,335		606,335	6
7	Activities and Social Services	312,407		45,122	357,529		357,529	7
8	Other (specify):			619	619		619	8
9	**TOTAL Health Care and Programs**	881,310	18,962	64,209	964,482		964,482	9
	C. General Administration							
10	Administrative and Clerical	444,031	16,250	50,119	510,400		510,400	10
11	Marketing Materials, Promotions and Advertising			21,714	21,714		21,714	11
12	Employee Benefits and Payroll Taxes	503,552			503,552		503,552	12
13	Insurance-Property, Liability and Malpractice			54,184	54,184		54,184	13
14	Other (specify): telephone			16,375	16,375		16,375	14
15	**TOTAL General Administration**	947,583	16,250	142,392	1,106,225		1,106,225	15
16	**TOTAL Operating Expense (Sum of lines 5, 9 and 15)**	2,342,244	374,901	574,350	3,291,495	(619)	3,290,876	16
	Capital Expenses							
	D. Ownership							
17	Depreciation				290,119		290,119	17
18	Interest				119,000		119,000	18
19	Real Estate Taxes				815		815	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment							21
22	Other (specify):							22
23	**TOTAL Ownership**				409,934		409,934	23
24	**GRAND TOTAL (Sum of lines 16 and 23)**	2,342,244	374,901	574,350	3,701,429	(619)	3,700,810	24

Facility Name: Friedman Place Report Period Beginning: 070117 Ending: 063018

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	2	$ 34.35	1
2	Licensed Practical Nurses	2	26.89	2
3	Certified Nurse Assistants	12	14.03	3
4	Activity Director & Assistants	3	16.93	4
5	Social Service Workers	3	29.42	5
6	Head Cook	1	21.73	6
7	Cook Helpers/Assistants	12	13.39	7
8	Dishwashers			8
9	Maintenance Workers	1	17.97	9
10	Housekeepers	4	12.46	10
11	Laundry			11
12	Managers	3	44.14	12
13	Other Administrative	4	14.60	13
14	Clerical			14
15	Marketing			15
16	Other	1	29.22	16
17	Total (lines 1 thru 16)	47	$	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: 070117 Ending: 063018

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	$ 149,076	28	$ 149,091	$	$ 1,994,117	1
2											2
3											3
4											4
5											5
	Improvement Type										
6	various years purchases #2				2,037,367	74,079	28	74,086	7	982,163	6
7	building improvements				810,814	30,712	28	29,484	(1,228)	2,069,442	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)				$ 6,948,181	$ 253,867		$ 252,661	$ (1,221)	$ 3,051,605	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	$ 36,252	$		5	$ 242,892	18
19	Vehicles	36,361				5	36,361	19
20	TOTAL (lines 18 and 19)	$ 358,107	$ 36,252	$	$		$ 279,253	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 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	AJB	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
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					$ 1,700,000	$ 1,700,000			$ 119,000	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					$ 1,700,000	$ 1,700,000			$ 119,000	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:** 070117 **Ending:** 063018

XI. BALANCE SHEET - Unrestricted Operating Fund. **As of** 063018 **(last day of reporting year)**

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 268,759	$	1
2	Cash-Patient Deposits	14,496		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	388,220		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,692		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)**	$ 674,167	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	404,278		12
13	Land	1,028,500		13
14	Buildings, at Historical Cost	4,100,000		14
15	Leasehold Improvements, at Historical Cost	2,832,141		15
16	Equipment, at Historical Cost	345,647		16
17	Accumulated Depreciation (book methods)	(3,332,673)		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)**	$ 5,377,893	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,052,060	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,163	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,175		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,928		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)**	$ 144,266	$	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)**	$ 2,219,266	$	45
46	**TOTAL EQUITY**	$	$	46
47	**TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)**	$ 2,219,266	$	47

***(See instructions.)**

Facility Name: Friedman Place Report Period Beginning: 070117 Ending: 063018

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

	I. Revenue	1 Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	$ 3,030,990	1
2	Discounts and Allowances		2
3	**SUBTOTAL Resident Care (line 1 minus line 2)**	$ 3,030,990	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	685,410	12
13	Interest and Other Investment Income	4,626	13
14	**SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)**	$ 690,036	14
	D. Other Revenue (specify):		
15	**cell tower**	28,238	15
16			16
17	**SUBTOTAL Other Revenue (sum of lines 15 and 16)**	$ 28,238	17
18	**TOTAL REVENUE (sum of lines 3, 11, 14 and 17)**	$ 3,749,264	18

	II. Expenses	2 Amount	
	A. Operating Expenses		
19	General Services	1,220,169	19
20	Health Care/ Personal Care	964,482	20
21	General Administration	1,106,225	21
	B. Capital Expense		
22	Ownership	409,934	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)**	$ 3,700,810	28
29	**Income Before Income Taxes (line 18 minus line 28)**	$ 48,454	29
30	**Income Taxes**	$	30
31	**NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)**	$ 48,454	31
	III. Net Resident Care Revenue detailed by Payer Source		
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	TOTAL (This total must agree to Line 3)	$	37