

Facility Name & ID Number Selfhelp Home of Chicago

0018580 Report Period Beginning: 10/1/05 Ending: 9/30/06

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	30	Skilled (SNF)	30	10,950	1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	65	TOTALS	65	23,725	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF	1,666	7,109	2,099	10,874	8
9	SNF/PED					9
10	ICF	4,754	6,616		11,370	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,420	13,725	2,099	22,244	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.76%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/57

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number

of beds certified 30 and days of care provided 2,099

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 9/30/06 Fiscal Year: 9/30/06

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Selfhelp Home of Chicago # 0018580 Report Period Beginning: 10/1/05 Ending: 9/30/06

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	289,700		13,144	302,844		302,844		302,844		1
2	Food Purchase		253,048		253,048		253,048	(12,199)	240,849		2
3	Housekeeping	109,402	31,569		140,971		140,971		140,971		3
4	Laundry		29,915		29,915		29,915		29,915		4
5	Heat and Other Utilities			79,229	79,229		79,229		79,229		5
6	Maintenance	86,604		57,667	144,271		144,271	52,835	197,106		6
7	Other (specify):*										7
8	TOTAL General Services	485,706	314,532	150,040	950,278		950,278	40,636	990,914		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,526,001	132,226	2,120	1,660,347		1,660,347		1,660,347		10
10a	Therapy			154,873	154,873		154,873		154,873		10a
11	Activities	116,615	17,099	2,334	136,048		136,048		136,048		11
12	Social Services			1,412	1,412		1,412		1,412		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,642,616	149,325	160,739	1,952,680		1,952,680		1,952,680		16
	C. General Administration										
17	Administrative	64,337			64,337		64,337		64,337		17
18	Directors Fees										18
19	Professional Services			42,485	42,485		42,485		42,485		19
20	Dues, Fees, Subscriptions & Promotions			6,517	6,517		6,517	1,808	8,325		20
21	Clerical & General Office Expenses	204,333	10,487	15,694	230,514		230,514	(16,646)	213,868		21
22	Employee Benefits & Payroll Taxes			424,848	424,848		424,848		424,848		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,871	1,871		1,871		1,871		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			58,738	58,738		58,738		58,738		26
27	Other (specify):*										27
28	TOTAL General Administration	268,670	10,487	550,153	829,310		829,310	(14,838)	814,472		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,396,992	474,344	860,932	3,732,268		3,732,268	25,798	3,758,066		29

SEE ACCOUNTANTS' COMPILATION REPORT

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Selfhelp Home of Chicago

#0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			93,126	93,126		93,126	34,008	127,134			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,305	3,305		3,305	(3,305)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			54,180	54,180		54,180	(54,180)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			150,611	150,611		150,611	(23,477)	127,134			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		114,345		114,345		114,345		114,345			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		111		111		111		111			41
42	Provider Participation Fee			35,588	35,588		35,588		35,588			42
43	Other (specify):* Nonallowable Cost	14,027		49,517	63,544		63,544	(63,544)				43
44	TOTAL Special Cost Centers	14,027	114,456	85,105	213,588		213,588	(63,544)	150,044			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,411,019	588,800	1,096,648	4,096,467		4,096,467	(61,223)	4,035,244			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,199)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(89,265)	30		9
10	Interest and Other Investment Income	(3,305)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,851)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Page 5A</u>	(50,531)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (183,151)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	121,928		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 121,928		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (61,223)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp Home of Chicago

ID# 0018580

Report Period Beginning: 10/1/05

Ending: 9/30/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Disallow Outreach Program	\$ (36)	43	1
2	Disallow Marketing Salaries	(14,027)	43	2
3	Disallow Part A Lab	(12,468)	43	3
4	Disallow Part A X-Ray	(2,410)	43	4
5	Disallow Web Site	(625)	43	5
6	Miscellaneous Income Offset	(14,838)	21	6
7				7
8	Disallow Support Collateral	(120)	43	8
9	Disallow Gift Shop Purchases	(6,055)	43	9
10	Disallow Marketing Events	48	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(50,531)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,199)	0	0	0	0	0	0	0	0	0	0	(12,199)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	52,835	0	0	0	0	0	0	0	0	0	52,835	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,199)	52,835	0	40,636	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(14,838)	0	0	0	0	0	0	0	0	0	0	(14,838)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,838)	0	0	0	0	0	0	0	0	0	0	(14,838)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,037)	52,835	0	25,798	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(89,265)	123,273	0	0	0	0	0	0	0	0	0	34,008	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,305)	0	0	0	0	0	0	0	0	0	0	(3,305)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(54,180)	0	0	0	0	0	0	0	0	0	(54,180)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(92,570)	69,093	0	(23,477)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(63,544)	0	0	0	0	0	0	0	0	0	0	(63,544)	43
44	TOTAL Special Cost Centers	(63,544)	0	0	0	0	0	0	0	0	0	0	(63,544)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(183,151)	121,928	0	(61,223)	45								

Facility Name & ID Number

Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		The Selfhelp Home Inc.-Center Division	Chicago	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	6 Maintenance	\$	The Selfhelp Home, Inc. -Center Division	0.00%	\$ 52,835	\$ 52,835	1
2	V	30 Depreciation		The Selfhelp Home, Inc. -Center Division	0.00%	123,273	123,273	2
3	V	34 Rent	54,180	The Selfhelp Home, Inc. -Center Division	0.00%		(54,180)	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 54,180			\$ 176,108	\$ * 121,928	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago # 0018580 Report Period Beginning: 10/1/05 Ending: 9/30/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	See Attached Schedule 7A										3
4											4
5											5
6			No compensation or fees were paid to the Board of Directors.								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.
Provider # : 0018580
10/1/05 to 9/30/06

Schedule 7A

First Name	Last Name	Title	Function
Herbert	Roth	President	Board Member
Rolf	Weil	Imm. Past President	Board Member
Gerald	Franks	First Vice-President	Board Member
Bernard H.	Baum	Vice President	Board Member
M. Jay	Heilbrunn	Vice President	Board Member
Austin	Hirsch	Vice President	Board Member
Leni	Weil	Treasurer	Board Member
Daniel	Wolf	Assistant Treasurer	Board Member
Henry	Straus	Secretary	Board Member
Jack	Bierig	Director	Board Member
Richard	Eggener	Director	Board Member
Peter	Glaser	Director	Board Member
Richard	Greenthal	Director	Board Member
Raphael	Juss	Director	Board Member
Gary	Kahn	Director	Board Member
Kurt B.	Karmin	Director	Board Member
Helen	Levy	Director	Board Member
Martha	Loewenthal	Director	Board Member
Steven	Loewenthal	Director	Board Member
Stephen	Nechtow	Director	Board Member
Barbara	Passman	Director	Board Member
Michael	Ries	Director	Board Member
George	Rosenbaum	Director	Board Member
Judith	Wolf	Director	Board Member

No directors provided goods or services to the organization or controlled businesses that provided goods or services to the organization

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/1/05

Ending: 9/30/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10				N/A					10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6																				
7																				
8																				
9	TOTAL Facility Related																			
B. Non-Facility Related*																				
10							Miscellaneous Interest Expense		3,305	10										
11							Interest Income Offset		(3,305)	11										
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)																			

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Selfhelp Home of Chicago COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0018580

CONTACT PERSON REGARDING THIS REPORT Mr. Marvin Rubin

TELEPHONE (773) 271-0300 FAX #: (773) 271-0633

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	<u>N/A</u>	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 73,944 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

The Selfhelp Home, Inc.: Retirement Facility; 92 Apartments; Square Footage of 80,832

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Resident Care</u>	<u>70,000</u>	<u>1970</u>	<u>\$ 191,769</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	70,000		\$ 191,769	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65		1974	1974	\$ 822,760	\$	50	\$ 16,456	\$ 16,456	\$ 518,340	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System		1980		786		15			786	9
10	Security System		1981		29,527		15			29,527	10
11	Building Improvements		1981		808		20			808	11
12	Building Improvements		1982		2,642		15			2,642	12
13	Building Improvements		1983		2,717		10			2,717	13
14	Building Improvements		1986		1,212		10			1,212	14
15	Building Improvements		1987		3,000		10			3,000	15
16	Building Improvements		1988		6,752		10			6,752	16
17	Building Improvements		1989		30,538		10			30,538	17
18	Building Improvement		1990		10,425		10			10,425	18
19	Building Improvements		1991		9,690		10			9,690	19
20	Building Improvements		1992		22,014		10			22,014	20
21	Building Improvements		1992		932		7			932	21
22	Building Improvements		1993		14,166		10			14,166	22
23	Building Improvements		1993		183		7			183	23
24	Building Improvements		1994		27,620		10			27,620	24
25	Building Improvements		1994		3,836		5			3,836	25
26	Building Improvements		1994		5,148		7			5,148	26
27	Building Improvements		1995		18,411		10			18,411	27
28	Building Improvements		1995		363		7			363	28
29	Building Improvements		1995		176,882	8,844	20	8,844		101,706	29
30	Building Improvements		1995		15,209		5			15,209	30
31	Building Improvements		1994		33,000		5			33,000	31
32	Fence		1996		6,704	202	20	335	133	3,357	32
33	Decorating		1996		5,905	136	20	295	159	2,650	33
34	Blacktop Resurfacing		1996		1,646	50	20	82	32	820	34
35	Security Camera		1996		895	26	20	45	19	444	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Boiler repairs	1996	\$ 5,914	\$ 158	20	\$ 296	\$ 138	\$ 2,960	37
38	Emergency call system	1996	14,557	58	20	728	670	7,280	38
39	Cabinets & vanities	1997	2,938	34	20	147	113	1,305	39
40	Fire Alarms	1997	12,818	486	20	641	155	6,167	40
41	Elevator Improvements	1997	6,171	98	20	309	211	2,732	41
42	Ceiling	1997	563		20	28	28	280	42
43	Tubing and piping	1997	1,667	19	20	83	64	821	43
44	Faucets	1997	999		20	50	50	500	44
45	Flooring	1997	2,152	80	20	108	28	1,040	45
46	Air Conditioning	1997	1,505		20	75	75	750	46
47	Doors	1997	7,523	214	20	376	162	3,653	47
48	Cement Work	1997	1,275	32	20	64	32	624	48
49	Windows	1997	51,709		20	2,585	2,585	25,850	49
50	Outdoor Sprinklers	1997	2,573	64	20	129	65	1,257	50
51	Bathub & Toilet	1997	605		20	30	30	300	51
52	Tuckpointing	1997	4,583		20	229	229	2,290	52
53	Blinds	1997	1,255	63	20	63		598	53
54	Boiler	1997	1,097		20	55	55	550	54
55	Office Refurbishing	1997	908	33	20	45	12	434	55
56	Compressor and Base Board	1997	680		20	34	34	340	56
57	Fire Alarms	1998	20,992	524	20	1,050	526	9,187	57
58	Sound System	1998	862		20	43	43	767	58
59	Architect	1998	43,360	2,112	20	2,168	56	18,455	59
60	Windows	1998	4,588		20	229	229	2,061	60
61	Lights	1998	1,517		20	76	76	684	61
62	Kitchen Sink	1998	1,230	62	20	62	(1)	527	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,447,812	\$ 13,295		\$ 35,759	\$ 22,464	\$ 957,707	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,447,812	\$ 13,295		\$ 35,759	\$ 22,464	\$ 957,707	1
2	Doors & Locks	1998	685		20	34	34	306	2
3	Audio/Visual System	1998	10,578	264	20	529	265	4,629	3
4	Wall/Windows	1998	2,222	62	20	111	49	968	4
5	Cabinets & Vanities	1998	1,300		20	65	65	585	5
6	Electrical Work	1998	11,441	284	20	572	288	5,006	6
7	Heating & Cooling	1998	9,470	236	20	474	238	4,147	7
8	Roof	1998	8,333		20	417	417	3,753	8
9	Floor Coverings	1998	3,067		20	153	153	1,377	9
10	Computer Wiring	1998	6,242	312	20	312		2,652	10
11	Handrails & Grab Bars	1998	6,020	301	20	301		2,559	11
12	Lights	1999	1,217		20	60	60	450	12
13	Floor Coverings	1999	4,564		20	228	228	1,710	13
14	Heating & Cooling	1999	1,373		20	68	68	510	14
15	Elevator	1999	37,272	194	20	1,864	1,670	13,980	15
16	Cabinets	1999	2,251		20	112	112	840	16
17	Wall	1999	2,790		20	140	140	1,050	17
18	Fire Alarm	1999	14,911	658	20	746	88	5,595	18
19	Roof	1999	35,283	160	20	1,597	1,437	12,228	19
20	Call/Paging System	1999	5,142	164	20	258	94	1,935	20
21	Pipes & Faucet	1999	865		20	44	44	330	21
22	Room Conversion	1999	3,169		20	158	158	1,185	22
23	Fire Ducts	1999	35,113	1,756	20	1,756		13,170	23
24	Security System	1999	13,503	676	20	676		5,070	24
25	Electrical Wiring	1999	20,805	1,040	20	1,040		7,800	25
26	Architect	1999	540	28	20	28		210	26
27	Blinds	2000	1,050		20	53	53	371	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,687,018	\$ 19,430		\$ 47,554	\$ 28,124	\$ 1,050,122	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,687,018	\$ 19,430		\$ 47,554	\$ 28,124	\$ 1,050,122	1
2	Cabinets	2000	3,135	23	20	134	111	938	2
3	Lobby Renovation	2000	3,397		20	170	170	1,190	3
4	Dining Room Renovation	2000	7,818	38	20	353	315	2,471	4
5	Washroom Renovation	2000	1,039		20	52	52	364	5
6	Light Fixtures	1999	893		20	45	45	315	6
7	Room Conversion	2000	673		20	34	34	238	7
8	Closet/Coat Room	2000	205		20	10	10	70	8
9	Doors	2000	1,568	5	20	73	68	511	9
10	Tiles	1999	140		20	7	7	49	10
11	Air Conditioner	2000	90		20	4	4	28	11
12	Resident Call System	2000	14,103	394	20	394		2,758	12
13	Heating & Cooling	2000	838		20	42	42	294	13
14	Ceiling Fan	1999	287		20	14	14	98	14
15	Dining Room Window	2001	1,834		20	92	92	506	15
16	Code Alert System	2001	2,501		20	125	125	687	16
17	Shower Temperature Control	2001	1,797	90	20	90		495	17
18	Call Station Living Room	2001	3,015	150	20	151	1	830	18
19	Doorknobs	2001	2,866		20	144	144	792	19
20	Repaving	2001	8,381		20	419	419	2,305	20
21	Fence	2001	784		20	40	40	220	21
22	Key Pad Locks	2001	776		20	39	39	214	22
23	Renovation of Kitchen, Basement & Elevator	2001	450,392	33,115	20	22,520	(10,595)	123,860	23
24	Elevator- Steel Frame	2001	533	54	20	27	(27)	121	24
25	Hot Water Tank	2001	2,070	98	20	104	6	468	25
26	Feed Pump	2001	2,300	230	20	115	(115)	518	26
27	Coils & Drains	2002	8,650	866	20	216	(650)	1,080	27
28	Boiler	2001	3,375	338	20	169	(169)	760	28
29	Carpeting	2002	28,345	1,418	20	1,417	(1)	6,377	29
30	Compressor	2002	3,375	338	20	169	(169)	760	30
31	Motorized Dampers	2002	18,547	928	20	927	(1)	4,172	31
32	Smoke Detectors and Duct Work	2002	9,644	482	20	482	0	2,169	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,270,389	\$ 57,997		\$ 76,132	\$ 18,135	\$ 1,205,780	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 2,270,389	\$ 57,997		\$ 76,132	\$ 18,135	\$ 1,205,780	1
2	Stock ceiling tile	2003	260	10	20	13	3	46	2
3	Heaters	2003	6,082	250	20	304	54	1,064	3
4	8th floor cabinets	2003	1,593	80	20	80	(0)	280	4
5	Water pump	2003	6,917	168	20	346	178	1,211	5
6	Replace 2 motors	2003	634	64	20	32	(32)	112	6
7	Exhaust fan	2003	925		20	46	46	161	7
8	Duct work	2003	7,202	250	20	360	110	1,260	8
9	Pipes changed	2003	1,300	130	20	65	(65)	228	9
10	Water heaters and water tank	2003	13,335	1,332	20	667	(665)	2,334	10
11	Vanities	2003	319		20	16	16	56	11
12	Carpeting	2003	2,623		20	131	131	459	12
13	Compressor	2003	12,306	862	20	615	(247)	2,153	13
14	1st floor hallway 930 bld	2003	1,101		20	55	55	193	14
15	Refridg pressure, safety valve, & mixer	2003	1,056	52	20	53	1	185	15
16	A/C and temperature control	2003	2,359	134	20	118	(16)	409	16
17	Locks and keypads	2003	1,234	27	20	62	35	221	17
18	Elevator	2003	8,143		20	408	408	1,426	18
19	Solarium	2003	143,632	8,292	20	7,182	(1,110)	25,137	19
20	Dampers	2003	7,680	192	20	192		576	20
21	Exhaust fan	2003	6,093	305	20	305		762	21
22	Bathroom work	2003	894	45	20	45		112	22
23	Water Pump & motor	2003	6,850	343	20	343		857	23
24	Entrance door	2003	1,474	74	20	74		185	24
25	Heaters	2004	10,988	549	20	549		1,373	25
26	Duct work	2004	3,111	156	20	156		390	26
27	Air handler	2004	3,845	192	20	192		480	27
28	Blower	2004	1,423	71	20	71		178	28
29	Blinds	2004	4,811	241	20	241		602	29
30	Pressure valve	2004	1,334	67	20	67		167	30
31	8th floor remodeling - oxygen room	2004	15,415	771	20	771		1,927	31
32	Condensor	2004	18,531	927	20	927		2,317	32
33	Cooling system	2004	2,695	135	20	135		337	33
34	TOTAL (lines 1 thru 33)		\$ 2,566,554	\$ 73,716		\$ 90,751	\$ 17,035	\$ 1,252,977	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 2,566,554	\$ 73,716		\$ 90,751	\$ 17,035	\$ 1,252,977	1
2	Refrigerator, water pressure and gas valves	2005	9,951	498	20	498		746	2
3	Water pump	2005	6,516	326	20	326		489	3
4	Heater	2005	5,190	259	20	259		389	4
5	Tuck pointing	2005	2,563	128	20	128		192	5
6	Air conditioners	2005	15,978	799	20	799		1,198	6
7	Door	2005	525	26	20	26		39	7
8	TV room	2005	3,928	196	20	196		294	8
9	Recreation room	2005	25,679	1,284	20	1,284		1,926	9
10	Landscaping	2005	2,048	102	20	102		153	10
11	Therapy Room Remodel	2006	15,847	396	20	396		396	11
12	Carpet	2006	3,921	98	20	98		98	12
13	Heater Units	2006	2,746	69	20	69		69	13
14	Driveway Gate	2006	1,257	31	20	31		31	14
15	Handicap Ramp	2006	1,475	37	20	37		37	15
16	Air Conditioners	2006	2,749	69	20	69		69	16
17	TV Room/Recreation Room	2006	22,414	560	20	560		560	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,689,340	\$ 78,595		\$ 95,630	\$ 17,035	\$ 1,259,664	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 433,199	\$ 12,747	\$ 29,720	\$ 16,973	5-7 Yrs	\$ 311,589	71
72	Current Year Purchases	24,971	1,784	1,784		5-7 Yrs	1,784	72
73	Fully Depreciated Assets	93,675					93,675	73
74								74
75	TOTALS	\$ 551,845	\$ 14,531	\$ 31,504	\$ 16,973		\$ 407,048	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		N/A		\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,432,954	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 93,126	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 127,134	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 34,008	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,666,712	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ N/A	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ N/A Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$ <u>N/A</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- SEE ACCOUNTANTS' COMPILATION REPORT**

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	5,891	\$ 55,965	\$	5,891	\$ 55,965	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		360	3,631		360	3,631	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,938	95,277		8,938	95,277	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				114,345		114,345	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	15,189	\$ 154,873	\$ 114,345	15,189	\$ 269,218	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago
 XV. BALANCE SHEET - Unrestricted Operating Fund.

0018580
 As of 9/30/06

Report Period Beginning: 10/1/05
 (last day of reporting year)

Ending: 9/30/06

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 337,778	\$ 337,778	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance -0-)	337,136	337,136	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,000	6,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	766,540	766,540	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,447,454	\$ 1,447,454	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		191,769	13
14	Buildings, at Historical Cost		822,760	14
15	Leasehold Improvements, at Historical Cost	1,618,493	1,866,580	15
16	Equipment, at Historical Cost	331,314	551,845	16
17	Accumulated Depreciation (book methods)	(808,211)	(1,666,712)	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)	\$ 1,141,596	\$ 1,766,242	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,589,050	\$ 3,213,696	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 82,514	\$ 82,514	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,376	51,376	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,629	3,629	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	97,522	97,522	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 235,041	\$ 235,041	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Interco A/C - Marx Fund</u>	67,527	67,527	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 67,527	\$ 67,527	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 302,568	\$ 302,568	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,286,482	\$ 2,911,128	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,589,050	\$ 3,213,696	48

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.
Provider #: 0018580
10/1/2005 to 09/30/2006

Schedule 17A

XV. BALANCE SHEET

<u>Other current Assets (specify) :</u>	<u>Operating</u>	<u>After Consolidation</u>
Bequest Receivable	692,124	692,124
Scholarship Loan Receivable	6,000	6,000
Scholarship Loan Payable	(4,207)	(4,207)
Interco A/C - Ries Fund	72,623	72,623
	<hr/>	<hr/>
Total Line 9 - Other Current Assets (specify) :	766,540	766,540

<u>Other Current Liabilities (specify):</u>	<u>Operating</u>	<u>After Consolidation</u>
Deferred Retirement Plan	84,083	84,083
Current Maturity Retirement Plan	6,000	6,000
Accrued Expenses	7,439	7,439
	<hr/>	<hr/>
Total Line 36 - Other Current Liabilities (specify) :	97,522	97,522

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,913,726	1
2	Restatements (describe):		2
3			3
4	Cumulative activity of funds other than healthcare facility	659,428	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,573,154	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(286,672)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (286,672)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,286,482	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,236,878	1
2	Discounts and Allowances for all Levels	216,638	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,453,516	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	160,781	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 160,781	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	12,242	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	12,199	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	98,259	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,059	19
20	Radiology and X-Ray	2,490	20
21	Other Medical Services	24,889	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 161,138	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,147	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,147	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Guest Apartment</u>	1,590	28
28a	<u>Miscellaneous Income</u>	20,623	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,213	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,809,795	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	950,278	31
32	Health Care	1,952,680	32
33	General Administration	829,310	33
B. Capital Expense			
34	Ownership	150,611	34
C. Ancillary Expense			
35	Special Cost Centers	178,000	35
36	Provider Participation Fee	35,588	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,096,467	40
41	Income before Income Taxes (line 30 minus line 40)**	(286,672)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (286,672)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.
-Tax Exempt Organization

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Selfhelp Home of Chicago**

0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 84,099	\$ 40.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	16,016	17,923	639,721	35.69	3
4	Licensed Practical Nurses	6,781	7,645	150,184	19.64	4
5	CNAs & Orderlies	61,794	70,126	651,997	9.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,736	9,996	116,615	11.67	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,168	2,168	34,041	15.70	13
14	Head Cook	5,557	5,557	78,744	14.17	14
15	Cook Helpers/Assistants	22,173	22,173	176,915	7.98	15
16	Dishwashers					16
17	Maintenance Workers	6,843	7,118	86,604	12.17	17
18	Housekeepers	11,660	13,392	109,402	8.17	18
19	Laundry					19
20	Administrator	1,660	1,660	64,337	38.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,051	10,765	204,333	18.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	500	500	14,027	28.05	33
34	TOTAL (lines 1 - 33)	156,019	171,103	\$ 2,411,019 *	\$ 14.09	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	303	\$ 13,144	1 (3)	35
36	Medical Director				36
37	Medical Records Consultant	53	2,120	10 (3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,334	11 (3)	44
45	Social Service Consultant	27	1,412	12 (3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	428	\$ 19,010		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Selfhelp Home of Chicago**

0018580

Report Period Beginning: **10/1/05**

Ending: **9/30/06**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Hedy Ciocci	Administrator	0	\$ 64,337	Workers' Compensation Insurance	\$ 77,662	IDPH License Fee	\$	
				Unemployment Compensation Insurance	10,665	Advertising: Employee Recruitment		
				FICA Taxes	185,404	Health Care Worker Background Check		
				Employee Health Insurance	129,615	(Indicate # of checks performed <u>54</u>)	1,808	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	3,705	
				Retirement Plan	21,502	Life Services Network of Illinois	2,812	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 64,337					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
N/A			\$				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 424,848	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,325
(Attach a copy of any management service agreement)								
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type	Amount		Description	Line #	Amount	Description	Amount
Sachnoff & Weaver	Legal	\$ 3,007						
Martin Brand	Accounting	1,312						
RSM McGladrey	Accounting	3,392		N/A				
Altschuler, Melvoin & Glasser LLP	Accounting	22,738						
Omnicare	Computer Consulting	4,034						
Paychex	Payroll Services	8,002						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Seminar Expense	1,871
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 42,485					
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 1,871

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5								N/A					
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/1/05

Ending:

9/30/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN \$2,812; IL Council \$3,705
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,286 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 35,588
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 12,199
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Altschuler, Melvojn & Glasser, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT