



Facility Name & ID Number Selfhelp Home of Chicago

# 0018580 Report Period Beginning: 10/01/07 Ending: 09/30/08

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	<u>30</u>	Skilled (SNF)	<u>30</u>	<u>10,980</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>35</u>	Intermediate (ICF)	<u>35</u>	<u>12,810</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>65</u>	TOTALS	<u>65</u>	<u>23,790</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>2,479</u>	<u>4,977</u>	<u>3,062</u>	<u>10,518</u>	8	
9	SNF/PED					9	
10	ICF	<u>1,698</u>	<u>9,658</u>		<u>11,356</u>	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	<u>4,177</u>	<u>14,635</u>	<u>3,062</u>	<u>21,874</u>	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.95%

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

Note: 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 3,062

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 09/30/08 Fiscal Year: 09/30/08

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

Facility Name & ID Number Selfhelp Home of Chicago # 0018580 Report Period Beginning: 10/01/07 Ending: 09/30/08

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	330,789		13,847	344,636		344,636		344,636		1
2	Food Purchase		283,672		283,672		283,672	(4,196)	279,476		2
3	Housekeeping	127,289	33,630		160,919		160,919		160,919		3
4	Laundry		44,532		44,532		44,532		44,532		4
5	Heat and Other Utilities			99,083	99,083		99,083		99,083		5
6	Maintenance	96,414		77,244	173,658		173,658	100,861	274,519		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	554,492	361,834	190,174	1,106,500		1,106,500	96,665	1,203,165		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,779,444	150,031	4,695	1,934,170		1,934,170		1,934,170		10
10a	Therapy			238,404	238,404		238,404		238,404		10a
11	Activities	118,326	18,768	1,800	138,894		138,894		138,894		11
12	Social Services			1,116	1,116		1,116		1,116		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,897,770	168,799	246,015	2,312,584		2,312,584		2,312,584		16
	<b>C. General Administration</b>										
17	Administrative	62,620			62,620		62,620		62,620		17
18	Directors Fees										18
19	Professional Services			50,165	50,165		50,165	(597)	49,568		19
20	Dues, Fees, Subscriptions & Promotions			8,519	8,519		8,519	800	9,319		20
21	Clerical & General Office Expenses	192,968	8,878	31,433	233,279		233,279	(21,077)	212,202		21
22	Employee Benefits & Payroll Taxes			544,292	544,292		544,292		544,292		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,511	2,511		2,511		2,511		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			41,178	41,178		41,178		41,178		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	255,588	8,878	678,098	942,564		942,564	(20,874)	921,690		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,707,850	539,511	1,114,287	4,361,648		4,361,648	75,791	4,437,439		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Selfhelp Home of Chicago

#0018580

Report Period Beginning:

10/01/07

Ending:

09/30/08

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			124,477	124,477		124,477	17,897	142,374			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,524	6,524		6,524	(6,524)				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	<b>TOTAL Ownership</b>			185,181	185,181		185,181	(42,807)	142,374			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,669		143,669		143,669		143,669			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		99		99		99		99			41
42	Provider Participation Fee			35,686	35,686		35,686		35,686			42
43	Other (specify):* <b>Non-allowable cost</b>	12,863		59,611	72,474		72,474	(71,827)	647			43
44	<b>TOTAL Special Cost Centers</b>	12,863	143,768	95,297	251,928		251,928	(71,827)	180,101			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,720,713	683,279	1,394,765	4,798,757		4,798,757	(38,843)	4,759,914			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

**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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,196)	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	(150,648)	30		9
10	Interest and Other Investment Income	(6,524)	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	(597)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(28,339)	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>	(63,765)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (254,069)		\$	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)	215,226		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 215,226		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (38,843)		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						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	
						52	

Selfhelp Home of Chicago

ID# 0018580

Report Period Beginning: 10/01/07

Ending: 09/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Gift Shop Purchases	\$ (5,306)	43	1
2	Disallow Part A Lab	(18,351)	43	2
3	Disallow Part A X-Ray	(5,870)	43	3
4	Disallow Marketing Events	(737)	43	4
5	Disallow Support Collateral	(98)	43	5
6	Disallow Web Site	(263)	43	6
7	Disallow Marketing salaries	(12,863)	43	7
8	Miscellaneous Income Offset	(20,277)	21	8
9				9
10	Reclass background checks	800	20	10
11	Reclass background checks	(800)	21	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	<b>Total</b>	(63,765)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/01/07

Ending:

09/30/08

## 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	(4,196)	0	0	0	0	0	0	0	0	0	0	(4,196)	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	100,861	0	0	0	0	0	0	0	0	0	100,861	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,196)</b>	<b>100,861</b>	<b>0</b>	<b>96,665</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
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	(597)	0	0	0	0	0	0	0	0	0	0	(597)	19
20	Fees, Subscriptions & Promotions	800	0	0	0	0	0	0	0	0	0	0	800	20
21	Clerical & General Office Expenses	(21,077)	0	0	0	0	0	0	0	0	0	0	(21,077)	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	<b>TOTAL General Administration</b>	<b>(20,874)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(20,874)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(25,070)</b>	<b>100,861</b>	<b>0</b>	<b>75,791</b>	<b>29</b>								

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/01/07

Ending:

09/30/08

## 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(150,648)	168,545	0	0	0	0	0	0	0	0	0	17,897	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,524)	0	0	0	0	0	0	0	0	0	0	(6,524)	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	<b>TOTAL Ownership</b>	<b>(157,172)</b>	<b>114,365</b>	<b>0</b>	<b>(42,807)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(71,827)	0	0	0	0	0	0	0	0	0	0	(71,827)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(71,827)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(71,827)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(254,069)</b>	<b>215,226</b>	<b>0</b>	<b>(38,843)</b>	<b>45</b>								

**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%	\$ 100,861	\$ 100,861	1
2	V	30 Depreciation		The Selfhelp Home, Inc.-Center Division	0.00%	168,545	168,545	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			\$ 269,406	\$ * 215,226	14

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

Facility Name &amp; ID Number

Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

10/01/07

Ending:

09/30/08

## 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**  
**10/1/07 to 9/30/08**

**Schedule 7A**

<b>First Name</b>	<b>Last Name</b>	<b>Title</b>	<b>Function</b>
Herbert	Roth	President	Board Member
Rolf	Weil	Imm. Past President	Board Member
Gerald	Franks	First 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	Eggner	Director	Board Member
Peter	Glaser	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
Bernard	Pritzker	Director	Board Member
Michael	Ries	Director	Board Member
George	Rosenbaum	Director	Board Member
Judith	Wolf	Director	Board Member
Brenda	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:

10/01/07

Ending: 09/30/08

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 \_\_\_\_\_

N/A

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	N/A								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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:

10/01/07

Ending:

09/30/08

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6																				
7																				
8																				
9	<b>TOTAL Facility Related</b>																			
<b>B. Non-Facility Related*</b>																				
10							<b>Miscellaneous Interest Expense</b>			<b>6,524</b>										
11							<b>Interest Income Offset</b>			<b>(6,524)</b>										
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>																			
15	<b>TOTALS (line 9+line14)</b>																			

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.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.

\$ \_\_\_\_\_ 1

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

\$ \_\_\_\_\_ 2

3. Under or (over) accrual (line 2 minus line 1).

\$ N/A 3

4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)

\$ \_\_\_\_\_ 4

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.

**(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**

\$ \_\_\_\_\_ 5

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.

**TOTAL REFUND \$ \_\_\_\_\_ For \_\_\_\_\_ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**

\$ \_\_\_\_\_ 6

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

\$ \_\_\_\_\_ 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	_____	11
	2007	N/A	12

Facility is a not for profit and does not pay real estate taxes.

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2007	\$ _____	13
14	PLUS APPEAL COST FROM LINE 5	\$ _____	14
15	LESS REFUND FROM LINE 6	\$ _____	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ _____	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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. _____	<u>N/A</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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   X   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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

10/01/07

Ending:

09/30/08

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	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	<b>TOTALS</b>	<b>70,000</b>		<b>\$ 191,769</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/01/07

Ending:

09/30/08**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	\$ 551,252	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
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		20	8,844	8,844	119,394	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		20	335	335	4,027	32
33	Decorating		1996	5,905		20	295	295	3,240	33
34	Blacktop Resurfacing		1996	1,646		20	82	82	984	34
35	Security Camera		1996	895		20	45	45	534	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 &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

10/01/07

Ending:

09/30/08

## 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	\$	20	\$ 296	\$ 296	\$ 3,552	37
38	Emergency call system	1996	14,557		20	728	728	8,736	38
39	Cabinets & vanities	1997	2,938		20	147	147	1,599	39
40	Fire Alarms	1997	12,818		20	641	641	7,449	40
41	Elevator Improvements	1997	6,171		20	309	309	3,350	41
42	Ceiling	1997	563		20	28	28	336	42
43	Tubing and piping	1997	1,667		20	83	83	987	43
44	Faucets	1997	999		20	50	50	600	44
45	Flooring	1997	2,152		20	108	108	1,256	45
46	Air Conditioning	1997	1,505		20	75	75	900	46
47	Doors	1997	7,523		20	376	376	4,405	47
48	Cement Work	1997	1,275		20	64	64	752	48
49	Windows	1997	51,709		20	2,585	2,585	31,020	49
50	Outdoor Sprinklers	1997	2,573		20	129	129	1,515	50
51	Bathub & Toilet	1997	605		20	30	30	360	51
52	Tuckpointing	1997	4,583		20	229	229	2,748	52
53	Blinds	1997	1,255		20	63	63	724	53
54	Boiler	1997	1,097		20	55	55	660	54
55	Office Refurbishing	1997	908		20	45	45	524	55
56	Compressor and Base Board	1997	680		20	34	34	408	56
57	Fire Alarms	1998	20,992		20	1,050	1,050	11,287	57
58	Sound System	1998	862		20	43	43	853	58
59	Architect	1998	43,360		20	2,168	2,168	22,791	59
60	Windows	1998	4,588		20	229	229	2,519	60
61	Lights	1998	1,517		20	76	76	836	61
62	Kitchen Sink	1998	1,230		20	62	62	651	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,447,812	\$		\$ 35,760	\$ 35,760	\$ 1,029,228	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:

10/01/07

Ending:

09/30/08**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	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,447,812	\$		\$ 35,760	\$ 35,760	\$ 1,029,228	1
2	Doors & Locks	1998	685		20	34	34	374	2
3	Audio/Visual System	1998	10,578		20	529	529	5,687	3
4	Wall/Windows	1998	2,222		20	111	111	1,190	4
5	Cabinets & Vanities	1998	1,300		20	65	65	715	5
6	Electrical Work	1998	11,441		20	572	572	6,150	6
7	Heating & Cooling	1998	9,470		20	474	474	5,095	7
8	Roof	1998	8,333		20	417	417	4,587	8
9	Floor Coverings	1998	3,067		20	153	153	1,683	9
10	Computer Wiring	1998	6,242		20	312	312	3,276	10
11	Handrails & Grab Bars	1998	6,020		20	301	301	3,161	11
12	Lights	1999	1,217		20	60	60	570	12
13	Floor Coverings	1999	4,564		20	228	228	2,166	13
14	Heating & Cooling	1999	1,373		20	68	68	646	14
15	Elevator	1999	37,272		20	1,864	1,864	17,708	15
16	Cabinets	1999	2,251		20	112	112	1,064	16
17	Wall	1999	2,790		20	140	140	1,330	17
18	Fire Alarm	1999	14,911		20	746	746	7,087	18
19	Roof	1999	35,283		20	1,597	1,597	15,422	19
20	Call/Paging System	1999	5,142		20	258	258	2,451	20
21	Pipes & Faucet	1999	865		20	44	44	418	21
22	Room Conversion	1999	3,169		20	158	158	1,501	22
23	Fire Ducts	1999	35,113		20	1,756	1,756	16,682	23
24	Security System	1999	13,503		20	676	676	6,422	24
25	Electrical Wiring	1999	20,805		20	1,040	1,040	9,880	25
26	Architect	1999	540		20	28	28	266	26
27	Blinds	2000	1,050		20	53	53	477	27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 1,687,018	\$		\$ 47,556	\$ 47,556	\$ 1,145,236	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

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## 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	<b>Totals from Page 12B, Carried Forward</b>		\$ 1,687,018	\$		\$ 47,556	\$ 47,556	\$ 1,145,236	1
2	Cabinets	2000	3,135		20	134	134	1,206	2
3	Lobby Renovation	2000	3,397		20	170	170	1,530	3
4	Dining Room Renovation	2000	7,818		20	353	353	3,177	4
5	Washroom Renovation	2000	1,039		20	52	52	468	5
6	Light Fixtures	1999	893		20	45	45	405	6
7	Room Conversion	2000	673		20	34	34	306	7
8	Closet/Coat Room	2000	205		20	10	10	90	8
9	Doors	2000	1,568		20	73	73	657	9
10	Tiles	1999	140		20	7	7	63	10
11	Air Conditioner	2000	90		20	4	4	36	11
12	Resident Call System	2000	14,103		20	394	394	3,546	12
13	Heating & Cooling	2000	838		20	42	42	378	13
14	Ceiling Fan	1999	287		20	14	14	126	14
15	Dining Room Window	2001	1,834		20	92	92	690	15
16	Code Alert System	2001	2,501		20	125	125	937	16
17	Shower Temperature Control	2001	1,797		20	90	90	675	17
18	Call Station Living Room	2001	3,015		20	151	151	1,132	18
19	Doorknobs	2001	2,866		20	144	144	1,080	19
20	Repaving	2001	8,381		20	419	419	3,143	20
21	Fence	2001	784		20	40	40	300	21
22	Key Pad Locks	2001	776		20	39	39	292	22
23	Renovation of Kitchen, Basement & Elevator	2001	450,392		20	22,520	22,520	168,900	23
24	Elevator- Steel Frame	2001	533		20	27	27	175	24
25	Hot Water Tank	2001	2,070		20	104	104	676	25
26	Feed Pump	2001	2,300		20	115	115	748	26
27	Coils & Drains	2002	8,650		20	216	216	1,512	27
28	Boiler	2001	3,375		20	169	169	1,098	28
29	Carpeting	2002	28,345		20	1,417	1,417	9,211	29
30	Compressor	2002	3,375		20	169	169	1,098	30
31	Motorized Dampers	2002	18,547		20	927	927	6,026	31
32	Smoke Detectors and Duct Work	2002	9,644		20	482	482	3,133	32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,270,389	\$		\$ 76,134	\$ 76,134	\$ 1,358,050	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

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## 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	<b>Totals from Page 12C, Carried Forward</b>		\$ 2,270,389	\$		\$ 76,134	\$ 76,134	\$ 1,358,050	1
2	Stock ceiling tile	2003	260		20	13	13	72	2
3	Heaters	2003	6,082		20	304	304	1,672	3
4	8th floor cabinets	2003	1,593		20	80	80	440	4
5	Water pump	2003	6,917		20	346	346	1,903	5
6	Replace 2 motors	2003	634		20	32	32	176	6
7	Exhaust fan	2003	925		20	46	46	253	7
8	Duct work	2003	7,202		20	360	360	1,980	8
9	Pipes changed	2003	1,300		20	65	65	358	9
10	Water heaters and water tank	2003	13,335		20	667	667	3,668	10
11	Vanities	2003	319		20	16	16	88	11
12	Carpeting	2003	2,623		20	131	131	721	12
13	Compressor	2003	12,306		20	615	615	3,383	13
14	1st floor hallway 930 bld	2003	1,101		20	55	55	303	14
15	Refridg pressure, safety valve, & mixer	2003	1,056		20	53	53	291	15
16	A/C and temperature control	2003	2,359		20	118	118	645	16
17	Locks and keypads	2003	1,234		20	62	62	345	17
18	Elevator	2003	8,143		20	408	408	2,242	18
19	Solarium	2003	143,632		20	7,182	7,182	39,501	19
20	Dampers	2003	7,680		20	192	192	960	20
21	Exhaust fan	2003	6,093		20	305	305	1,372	21
22	Bathroom work	2003	894		20	45	45	202	22
23	Water Pump & motor	2003	6,850		20	343	343	1,543	23
24	Entrance door	2003	1,474		20	74	74	333	24
25	Heaters	2004	10,988		20	549	549	2,471	25
26	Duct work	2004	3,111		20	156	156	702	26
27	Air handler	2004	3,845		20	192	192	864	27
28	Blower	2004	1,423		20	71	71	320	28
29	Blinds	2004	4,811		20	241	241	1,084	29
30	Pressure valve	2004	1,334		20	67	67	301	30
31	8th floor remodeling - oxygen room	2004	15,415		20	771	771	3,469	31
32	Condensor	2004	18,531		20	927	927	4,171	32
33	Cooling system	2004	2,695		20	135	135	607	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,566,554	\$		\$ 90,755	\$ 90,755	\$ 1,434,490	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Selfhelp Home of Chicago

# 0018580

Report Period Beginning:

10/01/07

Ending:

09/30/08

## 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	<b>Totals from Page 12D, Carried Forward</b>		\$ 2,566,554	\$		\$ 90,755	\$ 90,755	\$ 1,434,490	1
2	Refrigerator, water pressure and gas valves	2005	9,951		20	498	498	1,742	2
3	Water pump	2005	6,516		20	326	326	1,141	3
4	Heater	2005	5,190		20	260	260	908	4
5	Tuck pointing	2005	2,563		20	128	128	448	5
6	Air conditioners	2005	15,978		20	799	799	2,796	6
7	Door	2005	525		20	26	26	91	7
8	TV room	2005	3,928		20	196	196	686	8
9	Recreation room	2005	25,679		20	1,284	1,284	4,494	9
10	Landscaping	2005	2,048		20	102	102	357	10
11	Therapy Room Remodel	2006	15,847		20	792	792	1,980	11
12	Carpet	2006	3,921		20	196	196	490	12
13	Heater Units	2006	2,746		20	137	137	343	13
14	Driveway Gate	2006	1,257		20	63	63	157	14
15	Handicap Ramp	2006	1,475		20	74	74	185	15
16	Air Conditioners	2006	2,749		20	137	137	343	16
17	TV Room/Recreation Room	2006	22,414		20	1,121	1,121	2,802	17
18	Labor for Call System, Tub, Tiling, Bathroom, Hallways	2007	76,217		20	3,811	3,811	3,810	18
19	8th fl bath mirrors, drywall, studs, lighting, tiling	2007	50,450		20	2,523	2,523	3,784	19
20	Pictures, Bedside lamp, window covering, granite counters	2007	64,311		20	3,216	3,216	4,823	20
21	Mirrors, drywall, studs, tiling, HC Bathrooms	2007	41,152		20	2,058	2,058	3,086	21
22	Flooring, ceiling, light, hardware for therapy room	2007	10,949		20	547	547	821	22
23	New roof	2007	12,500		20	625	625	938	23
24	Elevator recall system	2007	33,640		20	1,682	1,682	2,523	24
25	New call system	2007	62,208		20	3,110	3,110	4,666	25
26	Paneling for 7th & 8th floor	2007	67,995		20	3,400	3,400	5,100	26
27	Carpet for healthcare floors hallway	2007	30,574		20	1,529	1,529	2,293	27
28	Mirrors, drywall, studs, tiling, HC Bathrooms	2007	17,725		20	886	886	1,329	28
29									29
30	HC Bath & Bed Rooms - Paint, Flooring, Mirrors, & Hardware	2008	64,925		20	1,623	1,623	1,623	30
31									31
32	Trial Balance Depreciation for Building Improve	2008		104,006			(104,006)		32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 3,221,987	\$ 104,006		\$ 121,903	\$ 17,897	\$ 1,488,249	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:

10/01/07

Ending:

09/30/08

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	\$ 499,925	\$ 17,092	\$ 17,092	\$	5-7 Yrs	\$ 349,968	71
72	Current Year Purchases	33,791	3,379	3,379		5-7 Yrs	3,379	72
73	Fully Depreciated Assets	93,675					93,675	73
74								74
75	TOTALS	\$ 627,391	\$ 20,471	\$ 20,471	\$		\$ 447,022	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)	\$ 4,041,147	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 124,477	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 142,374	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,897	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,935,271	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			\$	\$	17
18			<u>N/A</u>		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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	10A(3)	hrs	\$	1,706	\$ 102,353	\$	1,706	\$ 102,353	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		242	14,499		242	14,499	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,026	121,552		2,026	121,552	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				143,669		143,669	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	3,974	\$ 238,404	\$ 143,669	3,974	\$ 382,073	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 09/30/08

Report Period Beginning: 10/01/07  
 (last day of reporting year)

Ending: 09/30/08

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,071,988	\$ 1,071,988	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance ( -0- ))	416,628	416,628	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>	1,054,269	1,054,269	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,548,885	\$ 2,548,885	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		191,769	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	2,154,229	3,221,987	15
16	Equipment, at Historical Cost	406,860	627,391	16
17	Accumulated Depreciation (book methods)	(1,041,583)	(1,935,271)	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</b> (sum of lines 11 thru 23)	\$ 1,519,506	\$ 2,105,876	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,068,391	\$ 4,654,761	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 93,962	\$ 93,962	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	71,138	71,138	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,352	5,352	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
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Schedule 17A</u>	450,250	450,250	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 620,702	\$ 620,702	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Interco A/C</u>	68,272	68,272	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 68,272	\$ 68,272	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 688,974	\$ 688,974	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 3,379,417	\$ 3,965,787	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,068,391	\$ 4,654,761	48

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.  
Provider #: 0018580  
10/1/2007 to 09/30/2008

Schedule 17A

**XV. BALANCE SHEET**

<b>Other current Assets (specify) :</b>	<b>Operating</b>	<b>After Consolidation</b>
Interco A/C - Ries Fund	143,376	143,376
Bequest Receivable	909,100	909,100
Scholarship Loan Receivable	6,000	6,000
Scholarship Loan Payable	(4,207)	(4,207)
Total Line 9 - Other Current Assets (specify) :	<b>1,054,269</b>	<b>1,054,269</b>

<b>Other Current Liabilities (specify):</b>	<b>Operating</b>	<b>After Consolidation</b>
Deferred Retirement Plan	3,041	3,041
Deferred Retirement PI EE	124,037	124,037
Current Maturity Retirement Plan	6,000	6,000
Accrued Interest Deferred Re	18,673	18,673
Accrued Party Expense	(1,501)	(1,501)
Payable to Foundation	300,000	300,000
Total Line 36 - Other Current Liabilities (specify) :	<b>450,250</b>	<b>450,250</b>

See Accountants' Compilation Report

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>3,106,626</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>	<b>Cumulative activity of funds other than healthcare facility</b>	<b>(870,367)</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,236,259</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,143,158</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,143,158</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>3,379,417</b>	<b>24</b> *

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580Report Period Beginning: 10/01/07Ending: 09/30/08**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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,214,934	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,214,934	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	10,633	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,196	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	66,924	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 81,753	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	1,597,682	24
25	Interest and Other Investment Income***	24,545	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,622,227	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Guest Apartment</u>	540	28
28a	<u>Miscellaneous Income</u>	22,459	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 22,999	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,941,913	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,106,500	31
32	Health Care	2,312,584	32
33	General Administration	942,564	33
	<b>B. Capital Expense</b>		
34	Ownership	185,181	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	216,242	35
36	Provider Participation Fee	35,686	36
	<b>D. Other Expenses (specify):</b>		
37	<u>Rounding</u>	(2)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,798,755	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,143,158	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,143,158	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:

**10/01/07**

Ending:

**09/30/08**

**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	\$ 90,918	\$ 43.71	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	18,581	20,128	611,324	30.37	3
4	Licensed Practical Nurses	9,518	10,481	255,002	24.33	4
5	CNAs & Orderlies	60,849	67,942	822,200	12.10	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides					8
9	Activity Director	0	0	0		9
10	Activity Assistants	7,281	8,066	118,326	14.67	10
11	Social Service Workers	0	0	0		11
12	Dietician	0	0	0		12
13	Food Service Supervisor	1,694	1,694	34,027	20.08	13
14	Head Cook	5,541	5,541	74,876	13.51	14
15	Cook Helpers/Assistants	24,467	24,467	221,885	9.07	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	9,868	10,011	96,414	9.63	17
18	Housekeepers	10,733	12,321	127,289	10.33	18
19	Laundry	0	0	0		19
20	Administrator	1,373	1,373	62,620	45.61	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	10,104	10,869	192,968	17.75	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify) <u>Marketing</u>	520	520	12,864	24.74	33
34	TOTAL (lines 1 - 33)	162,610	175,494	\$ 2,720,713 *	\$ 15.50	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	319	\$ 13,847	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	36	1,440	L10, C3	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	35	1,800	L11, C3	44
45	Social Service Consultant	21	1,116	L12, C2	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	411	\$ 18,203		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	81	\$ 3,255	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	81	\$ 3,255		53

SEE ACCOUNTANTS' COMPILATION REPORT



Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.  
Provider #: 0018580  
10/1/2007 to 09/30/2008

Schedule21A

**Pg 21C - Professional Services**

Per Schedule agreeing with P3, L19, C3	50,165
Less: Non allowable legal fees	<u>(597)</u>
Total agreeing with P3, L19, C8	<u><u>49,568</u></u>

See Accountants' Compilation Report

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580

Report Period Beginning:

10/01/07

Ending:

09/30/08**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=\$3694; IL Council=\$4693
- (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? N/A
- (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? 5-7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 56,061 Line 10(2)
- (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. \$ 35,686  
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.

**SEE ACCOUNTANTS' COMPILATION REPORT**

- (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. \$ 4,196
- (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? Adequate records have been maintained.
- 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? No**  
**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: McGladrey & Pullen, 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 \$5,000, 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