

Facility Name & ID Number Selfhelp Home of Chicago

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

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

	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	193	4,880	3,028	8,101	8
9	SNF/PED					9
10	ICF	4,439	9,140		13,579	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,632	14,020	3,028	21,680	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.38%

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

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 3,028

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: 09/30/09 Fiscal Year: 09/30/09

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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
	A. General Services										
1	Dietary	334,485		13,118	347,603		347,603		347,603		1
2	Food Purchase		272,882		272,882		272,882	(600)	272,282		2
3	Housekeeping	130,379	34,542		164,921		164,921		164,921		3
4	Laundry		44,225		44,225		44,225		44,225		4
5	Heat and Other Utilities			104,511	104,511		104,511		104,511		5
6	Maintenance	96,676		70,255	166,931		166,931	104,331	271,262		6
7	Other (specify):*										7
8	TOTAL General Services	561,540	351,649	187,884	1,101,073		1,101,073	103,731	1,204,804		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,837,397	162,849	2,416	2,002,662		2,002,662		2,002,662		10
10a	Therapy			264,856	264,856		264,856		264,856		10a
11	Activities	126,665	16,791	2,071	145,527		145,527		145,527		11
12	Social Services			1,235	1,235		1,235		1,235		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,964,062	179,640	270,578	2,414,280		2,414,280		2,414,280		16
	C. General Administration										
17	Administrative	63,823			63,823		63,823		63,823		17
18	Directors Fees										18
19	Professional Services			61,935	61,935		61,935	477	62,412		19
20	Dues, Fees, Subscriptions & Promotions			9,458	9,458		9,458	848	10,306		20
21	Clerical & General Office Expenses	207,100	13,020	14,702	234,822		234,822	(6,932)	227,890		21
22	Employee Benefits & Payroll Taxes			554,103	554,103		554,103		554,103		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,306	3,306		3,306		3,306		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			38,460	38,460		38,460		38,460		26
27	Other (specify):*										27
28	TOTAL General Administration	270,923	13,020	681,964	965,907		965,907	(5,607)	960,300		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,796,525	544,309	1,140,426	4,481,260		4,481,260	98,124	4,579,384		29

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

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

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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	
	D. Ownership											
30	Depreciation			145,059	145,059		145,059	16,879	161,938			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,591	8,591		8,591	(7,867)	724			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			207,830	207,830		207,830	(45,168)	162,662			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		154,525		154,525		154,525		154,525			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		129		129		129		129			41
42	Provider Participation Fee			35,588	35,588		35,588		35,588			42
43	Other (specify):* Non-allowable cost	13,508		63,769	77,277		77,277	(77,277)				43
44	TOTAL Special Cost Centers	13,508	154,654	99,357	267,519		267,519	(77,277)	190,242			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,810,033	698,963	1,447,613	4,956,609		4,956,609	(24,321)	4,932,288			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	(600)	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	(148,446)	30		9
10	Interest and Other Investment Income	(7,867)	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	477	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(25,699)	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 See PG5A	(57,662)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (239,797)		\$	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)	215,476		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 215,476		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (24,321)		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	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Gift Shop Purchases	\$ (5,453)	43	1
2	Disallow Part A Lab	(23,489)	43	2
3	Disallow Part A X-Ray	(8,502)	43	3
4	Disallow Marketing Events	(58)	43	4
5	Disallow Part B Coinsurance Bad Debts	(12)	43	5
6	Disallow Web Site	(556)	43	6
7	Disallow Marketing Salaries	(13,508)	43	7
8	Miscellaneous Income Offset	(6,084)	21	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
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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	(57,662)		49

SEE ACCOUNTANTS' COMPILATION REPORT

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 Div.	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%	\$ 104,331	\$ 104,331	1
2	V	30 Depreciation		The Selfhelp Home, Inc.-Center Division	0.00%	165,325	165,325	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			\$ 269,656	\$ * 215,476	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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

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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

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

Name of Related Organization _____
 Street Address N/A
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

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IX. INTEREST EXPENSE

Important, please see the next worksheet, "RE_Tax". The

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2008 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.)	2008	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$ N/A	3
4. Real Estate Tax accrual used for 2009 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:	2004	8	
	2005	9	
	2006	10	
	2007	11	
	2008	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 2008 \$	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.

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 567,708	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		20	8,844	8,844	128,238	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	4,362	32
33	Decorating		1996	5,905		20	295	295	3,535	33
34	Blacktop Resurfacing		1996	1,646		20	82	82	1,066	34
35	Security Camera		1996	895		20	45	45	579	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

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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	
37	Boiler repairs	1996	\$ 5,914	\$	20	\$ 296	\$ 296	\$ 3,848	37
38	Emergency call system	1996	14,557		20	728	728	9,464	38
39	Cabinets & vanities	1997	2,938		20	147	147	1,746	39
40	Fire Alarms	1997	12,818		20	641	641	8,090	40
41	Elevator Improvements	1997	6,171		20	309	309	3,659	41
42	Ceiling	1997	563		20	28	28	364	42
43	Tubing and piping	1997	1,667		20	83	83	1,070	43
44	Faucets	1997	999		20	50	50	650	44
45	Flooring	1997	2,152		20	108	108	1,364	45
46	Air Conditioning	1997	1,505		20	75	75	975	46
47	Doors	1997	7,523		20	376	376	4,781	47
48	Cement Work	1997	1,275		20	64	64	816	48
49	Windows	1997	51,709		20	2,585	2,585	33,605	49
50	Outdoor Sprinklers	1997	2,573		20	129	129	1,644	50
51	Bathub & Toilet	1997	605		20	30	30	390	51
52	Tuckpointing	1997	4,583		20	229	229	2,977	52
53	Blinds	1997	1,255		20	63	63	787	53
54	Boiler	1997	1,097		20	55	55	715	54
55	Office Refurbishing	1997	908		20	45	45	569	55
56	Compressor and Base Board	1997	680		20	34	34	442	56
57	Fire Alarms	1998	20,992		20	1,050	1,050	12,337	57
58	Sound System	1998	862		20	43	43	896	58
59	Architect	1998	43,360		20	2,168	2,168	24,959	59
60	Windows	1998	4,588		20	229	229	2,748	60
61	Lights	1998	1,517		20	76	76	912	61
62	Kitchen Sink	1998	1,230		20	62	62	713	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	\$ 1,064,988	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:

10/01/08

Ending:

09/30/09**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	\$		\$ 35,760	\$ 35,760	\$ 1,064,988	1
2	Doors & Locks	1998	685		20	34	34	408	2
3	Audio/Visual System	1998	10,578		20	529	529	6,216	3
4	Wall/Windows	1998	2,222		20	111	111	1,301	4
5	Cabinets & Vanities	1998	1,300		20	65	65	780	5
6	Electrical Work	1998	11,441		20	572	572	6,722	6
7	Heating & Cooling	1998	9,470		20	474	474	5,569	7
8	Roof	1998	8,333		20	417	417	5,004	8
9	Floor Coverings	1998	3,067		20	153	153	1,836	9
10	Computer Wiring	1998	6,242		20	312	312	3,588	10
11	Handrails & Grab Bars	1998	6,020		20	301	301	3,462	11
12	Lights	1999	1,217		20	60	60	630	12
13	Floor Coverings	1999	4,564		20	228	228	2,394	13
14	Heating & Cooling	1999	1,373		20	68	68	714	14
15	Elevator	1999	37,272		20	1,864	1,864	19,572	15
16	Cabinets	1999	2,251		20	112	112	1,176	16
17	Wall	1999	2,790		20	140	140	1,470	17
18	Fire Alarm	1999	14,911		20	746	746	7,833	18
19	Roof	1999	35,283		20	1,597	1,597	17,019	19
20	Call/Paging System	1999	5,142		20	258	258	2,709	20
21	Pipes & Faucet	1999	865		20	44	44	462	21
22	Room Conversion	1999	3,169		20	158	158	1,659	22
23	Fire Ducts	1999	35,113		20	1,756	1,756	18,438	23
24	Security System	1999	13,503		20	676	676	7,098	24
25	Electrical Wiring	1999	20,805		20	1,040	1,040	10,920	25
26	Architect	1999	540		20	28	28	294	26
27	Blinds	2000	1,050		20	53	53	530	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,687,018	\$		\$ 47,556	\$ 47,556	\$ 1,192,792	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:

10/01/08

Ending:

09/30/09

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	\$		\$ 47,556	\$ 47,556	\$ 1,192,792	1
2	Cabinets	2000	3,135		20	134	134	1,340	2
3	Lobby Renovation	2000	3,397		20	170	170	1,700	3
4	Dining Room Renovation	2000	7,818		20	353	353	3,530	4
5	Washroom Renovation	2000	1,039		20	52	52	520	5
6	Light Fixtures	1999	893		20	45	45	450	6
7	Room Conversion	2000	673		20	34	34	340	7
8	Closet/Coat Room	2000	205		20	10	10	100	8
9	Doors	2000	1,568		20	73	73	730	9
10	Tiles	1999	140		20	7	7	70	10
11	Air Conditioner	2000	90		20	4	4	40	11
12	Resident Call System	2000	14,103		20	394	394	3,940	12
13	Heating & Cooling	2000	838		20	42	42	420	13
14	Ceiling Fan	1999	287		20	14	14	140	14
15	Dining Room Window	2001	1,834		20	92	92	782	15
16	Code Alert System	2001	2,501		20	125	125	1,062	16
17	Shower Temperature Control	2001	1,797		20	90	90	765	17
18	Call Station Living Room	2001	3,015		20	151	151	1,283	18
19	Doorknobs	2001	2,866		20	144	144	1,224	19
20	Repaving	2001	8,381		20	419	419	3,562	20
21	Fence	2001	784		20	40	40	340	21
22	Key Pad Locks	2001	776		20	39	39	331	22
23	Renovation of Kitchen, Basement & Elevator	2001	450,392		20	22,520	22,520	191,420	23
24	Elevator- Steel Frame	2001	533		20	27	27	202	24
25	Hot Water Tank	2001	2,070		20	104	104	780	25
26	Feed Pump	2001	2,300		20	115	115	863	26
27	Coils & Drains	2002	8,650		20	216	216	1,728	27
28	Boiler	2001	3,375		20	169	169	1,267	28
29	Carpeting	2002	28,345		20	1,417	1,417	10,628	29
30	Compressor	2002	3,375		20	169	169	1,267	30
31	Motorized Dampers	2002	18,547		20	927	927	6,953	31
32	Smoke Detectors and Duct Work	2002	9,644		20	482	482	3,615	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,270,389	\$		\$ 76,134	\$ 76,134	\$ 1,434,184	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:

10/01/08

Ending:

09/30/09

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	\$		\$ 76,134	\$ 76,134	\$ 1,434,184	1
2	Stock ceiling tile	2003	260		20	13	13	85	2
3	Heaters	2003	6,082		20	304	304	1,976	3
4	8th floor cabinets	2003	1,593		20	80	80	520	4
5	Water pump	2003	6,917		20	346	346	2,249	5
6	Replace 2 motors	2003	634		20	32	32	208	6
7	Exhaust fan	2003	925		20	46	46	299	7
8	Duct work	2003	7,202		20	360	360	2,340	8
9	Pipes changed	2003	1,300		20	65	65	423	9
10	Water heaters and water tank	2003	13,335		20	667	667	4,335	10
11	Vanities	2003	319		20	16	16	104	11
12	Carpeting	2003	2,623		20	131	131	852	12
13	Compressor	2003	12,306		20	615	615	3,998	13
14	1st floor hallway 930 bld	2003	1,101		20	55	55	358	14
15	Refridg pressure, safety valve, & mixer	2003	1,056		20	53	53	344	15
16	A/C and temperature control	2003	2,359		20	118	118	763	16
17	Locks and keypads	2003	1,234		20	62	62	407	17
18	Elevator	2003	8,143		20	408	408	2,650	18
19	Solarium	2003	143,632		20	7,182	7,182	46,683	19
20	Dampers	2003	7,680		20	192	192	1,152	20
21	Exhaust fan	2003	6,093		20	305	305	1,677	21
22	Bathroom work	2003	894		20	45	45	247	22
23	Water Pump & motor	2003	6,850		20	343	343	1,886	23
24	Entrance door	2003	1,474		20	74	74	407	24
25	Heaters	2004	10,988		20	549	549	3,020	25
26	Duct work	2004	3,111		20	156	156	858	26
27	Air handler	2004	3,845		20	192	192	1,056	27
28	Blower	2004	1,423		20	71	71	391	28
29	Blinds	2004	4,811		20	241	241	1,325	29
30	Pressure valve	2004	1,334		20	67	67	368	30
31	8th floor remodeling - oxygen room	2004	15,415		20	771	771	4,240	31
32	Condensor	2004	18,531		20	927	927	5,098	32
33	Cooling system	2004	2,695		20	135	135	742	33
34	TOTAL (lines 1 thru 33)		\$ 2,566,554	\$		\$ 90,755	\$ 90,755	\$ 1,525,245	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:

10/01/08

Ending:

09/30/09

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	\$		\$ 90,755	\$ 90,755	\$ 1,525,245	1
2	Refrigerator, water pressure and gas valves	2005	9,951		20	498	498	2,240	2
3	Water pump	2005	6,516		20	326	326	1,467	3
4	Heater	2005	5,190		20	260	260	1,168	4
5	Tuck pointing	2005	2,563		20	128	128	576	5
6	Air conditioners	2005	15,978		20	799	799	3,595	6
7	Door	2005	525		20	26	26	117	7
8	TV room	2005	3,928		20	196	196	882	8
9	Recreation room	2005	25,679		20	1,284	1,284	5,778	9
10	Landscaping	2005	2,048		20	102	102	459	10
11	Therapy Room Remodel	2006	15,847		20	792	792	2,772	11
12	Carpet	2006	3,921		20	196	196	686	12
13	Heater Units	2006	2,746		20	137	137	480	13
14	Driveway Gate	2006	1,257		20	63	63	220	14
15	Handicap Ramp	2006	1,475		20	74	74	259	15
16	Air Conditioners	2006	2,749		20	137	137	480	16
17	TV Room/Recreation Room	2006	22,414		20	1,121	1,121	3,923	17
18	Labor for Call System, Tub, Tiling, Bathroom, Hallways	2007	76,217		20	3,811	3,811	7,621	18
19	8th fl bath mirrors, drywall, studs, lighting, tiling	2007	50,450		20	2,523	2,523	6,307	19
20	Pictures, Bedside lamp, window covering, granite counters	2007	64,311		20	3,216	3,216	8,039	20
21	Mirrors, drywall, studs, tiling, HC Bathrooms	2007	41,152		20	2,058	2,058	5,144	21
22	Flooring, ceiling, light, hardware for therapy room	2007	10,949		20	547	547	1,368	22
23	New roof	2007	12,500		20	625	625	1,563	23
24	Elevator recall system	2007	33,640		20	1,682	1,682	4,205	24
25	New call system	2007	62,208		20	3,110	3,110	7,776	25
26	Paneling for 7th & 8th floor	2007	67,995		20	3,400	3,400	8,500	26
27	Carpet for healthcare floors hallway	2007	30,574		20	1,529	1,529	3,822	27
28	Mirrors, drywall, studs, tiling, HC Bathrooms	2007	17,725		20	886	886	2,214	28
29									29
30	HC Bath & Bed Rooms - Paint, Flooring, Mirrors, & Hardware	2008	64,925		20	3,246	3,246	4,869	30
31	HC Bath & Bed Rooms - Paint, Flooring, Mirrors, & Hardware	2009	177,949		20	4,449	4,449	4,449	31
32	Trial Balance Depreciation for Building Improve	2009		111,096			(111,096)		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,399,936	\$ 111,096		\$ 127,975	\$ 16,879	\$ 1,616,224	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:

10/01/08

Ending:

09/30/09

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	\$ 533,716	\$ 10,342	\$ 10,342	\$	5-7 Yrs	\$ 363,689	71
72	Current Year Purchases	236,218	23,621	23,621		5-7 Yrs	23,621	72
73	Fully Depreciated Assets	93,675					93,675	73
74								74
75	TOTALS	\$ 863,609	\$ 33,963	\$ 33,963	\$		\$ 480,985	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)	\$ 4,455,314	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 145,059	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 161,938	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,879	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,097,209	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? _____

If NO, see instructions. YES NO

		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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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>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. <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			
		1	2	3	4
		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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10A(3)	hrs			1,956	\$ 117,061					1,956	\$ 117,061			1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			264	18,737					264	18,737			2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A(3)	hrs			2,153	129,058					2,153	129,058			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							154,525			154,525			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	TOTAL				\$	4,373	\$ 264,856	\$ 154,525		4,373	\$ 419,381					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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,200,285	\$ 1,200,285	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>.0.</u>)	303,617	303,617	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>	345,559	345,559	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,855,461	\$ 1,855,461	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			14
15	Leasehold Improvements, at Historical Cost	2,314,453	3,399,936	15
16	Equipment, at Historical Cost	625,078	863,609	16
17	Accumulated Depreciation (book methods)	(1,199,017)	(2,097,209)	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 (spe <u>Capitalized fees</u>)	19,960	19,960	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,760,474	\$ 2,378,065	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,615,935	\$ 4,233,526	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 87,136	\$ 87,136	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,029	79,029	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,898	5,898	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>	209,647	209,647	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 381,710	\$ 381,710	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>Intercompany Payable</u>	68,658	68,658	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 68,658	\$ 68,658	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 450,368	\$ 450,368	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,165,567	\$ 3,783,158	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,615,935	\$ 4,233,526	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.
 Provider #: 0018580
 10/1/2008 to 09/30/2009

Schedule 17A

XV. BALANCE SHEET

Other current Assets (specify) :	Operating	After Consolidation
Interco A/C - Ries Fund	165,266	165,266
Bequest Receivable	165,000	165,000
Scholarship Loan Receivable	6,000	6,000
Scholarship Loan Payable	(4,207)	(4,207)
Donated Asset	13,500	13,500
 Total Line 9 - Other Current Assets (specify) :	 345,559	 345,559

Other Current Liabilities (specify):	Operating	After Consolidation
Deferred Retirement Plan	-	-
Deferred Retirement PI EE	152,306	152,306
Current Maturity Retirement Plan	3,431	3,431
Accrued Interest Deferred Re	27,264	27,264
Accrued Party Expense	26,646	26,646
Payable to Foundation	-	-
 Total Line 36 - Other Current Liabilities (specify) :	 209,647	 209,647

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,379,417	1
2	Restatements (describe):		2
3			3
4	Cumulative activity of funds other than health care facility	(609,647)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,769,770	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	395,797	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)	\$ 395,797	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)	\$ 3,165,567	24 *

* 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	\$ 4,475,367	1
2	Discounts and Allowances for all Levels	(11,892)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,463,475	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	10,412	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	13,441	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	69,182	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 93,035	23
	D. Non-Operating Revenue		
24	Contributions	754,399	24
25	Interest and Other Investment Income***	7,867	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 762,266	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	31,980	28
28a	<u>Guest Apartment</u>	1,650	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 33,630	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,352,406	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,101,073	31
32	Health Care	2,414,280	32
33	General Administration	965,907	33
	B. Capital Expense		
34	Ownership	207,830	34
	C. Ancillary Expense		
35	Special Cost Centers	231,931	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)*	\$ 4,956,609	40
41	Income before Income Taxes (line 30 minus line 40)**	395,797	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 395,797	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:

10/01/08

Ending:

09/30/09

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	\$ 93,640	\$ 45.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	21,196	21,474	726,254	33.82	3
4	Licensed Practical Nurses	7,598	7,673	193,057	25.16	4
5	CNAs & Orderlies	66,276	67,412	824,446	12.23	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,940	7,940	126,665	15.95	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,713	1,713	35,108	20.50	13
14	Head Cook	4,245	4,245	63,128	14.87	14
15	Cook Helpers/Assistants	25,106	25,106	236,249	9.41	15
16	Dishwashers					16
17	Maintenance Workers	9,515	9,515	96,676	10.16	17
18	Housekeepers	12,185	12,185	130,379	10.70	18
19	Laundry					19
20	Administrator	1,373	1,373	63,823	46.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,747	15,785	207,100	13.12	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>	520	520	13,508	25.98	33
34	TOTAL (lines 1 - 33)	175,494	177,021	\$ 2,810,033 *	\$ 15.87	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	302	\$ 13,118	L1,C3	35
36	Medical Director				36
37	Medical Records Consultant	52	2,080	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	40	2,071	L11,C3	44
45	Social Service Consultant	23	1,235	L12,C2	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	417	\$ 18,504		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 336	L10,C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 336		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning: 10/01/08

Ending: 09/30/09

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	\$ 63,823	Workers' Compensation Insurance	\$ 100,288	IDPH License Fee	\$		
				Unemployment Compensation Insurance	7,528	Advertising: Employee Recruitment			
				FICA Taxes	221,939	Health Care Worker Background Check			
				Employee Health Insurance	195,689	(Indicate # of checks performed 53)	848		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Care	5,187		
				Employee Retirement	28,659	Life Services Network	2,207		
						Dietary Managers Association	135		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 63,823			AAHSA 2009 Dues	1,930		
(List each licensed administrator separately.)									
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 554,103		
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**			
N/A			\$	Description	Line #	Amount	Description	Amount	
							Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				In-State Travel		
(Attach a copy of any management service agreement)									
C. Professional Services				TOTAL			\$	Seminar Expense	3,306
Vendor/Payee	Type		Amount						
RSM McGlisdrey	Accounting		\$ 30,215						
Martin Brand	Accounting		1,313						
Paychex	Payroll Services		6,690						
Reed Smith	Legal		5,838						
Much Shelist	Legal		1,365						
American Data	Software		12,375						
Omnicare	Computer Consulting		4,140						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 61,935				Entertainment Expense	()	
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 3,306	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.
Provider # 0018580
10/1/2008 to 09/30/2009

Schedule21A

Pg 21C - Professional Services

Per Schedule agreeing with P3, L19, C3	61,935
Add: Allowable legal fees	<u>477</u>
Total agreeing with P3, L19, C8	<u><u>62,412</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
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2		N/A											
3													
4													
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17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580Report Period Beginning: 10/01/08Ending: 09/30/09**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=\$2207; Council=\$5187
- (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. \$ 67,735 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. \$ 35,588
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. \$ 600
- (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
- (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

SEE ACCOUNTANTS' COMPILATION REPORT