



Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580 Report Period Beginning: 10/01/16 Ending: 09/30/17

**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	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3	29	Intermediate (ICF)	29	10,585	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	801	8,306	4,635	13,742	8
9	SNF/PED					9
10	ICF	2,267	6,924		9,191	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,068	15,230	4,635	22,933	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.26%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 01/01/1957

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 43 and days of care provided 4,635

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: 09/30/2017 Fiscal Year: 09/30/2017

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

Facility Name & ID Number Selfhelp Home Of Chicago # 0018580 Report Period Beginning: 10/01/16 Ending: 09/30/17

**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	418,415		12,984	431,399		431,399		431,399		1
2	Food Purchase		265,788		265,788		265,788	(9,940)	255,848		2
3	Housekeeping	169,742	77,891		247,633		247,633		247,633		3
4	Laundry		71,743		71,743		71,743		71,743		4
5	Heat and Other Utilities			138,375	138,375		138,375		138,375		5
6	Maintenance	141,622		118,022	259,644		259,644	(47,282)	212,362		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	729,779	415,422	269,381	1,414,582		1,414,582	(57,222)	1,357,360		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,569,635	48,026	13,985	2,631,646		2,631,646		2,631,646		10
10a	Therapy										10a
11	Activities	128,655	17,363	1,330	147,348		147,348		147,348		11
12	Social Services			2,186	2,186		2,186		2,186		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,698,290	65,389	35,501	2,799,180		2,799,180		2,799,180		16
	<b>C. General Administration</b>										
17	Administrative	137,584			137,584		137,584		137,584		17
18	Directors Fees										18
19	Professional Services			71,239	71,239		71,239	(702)	70,537		19
20	Dues, Fees, Subscriptions & Promotions			50,770	50,770		50,770	(40,551)	10,219		20
21	Clerical & General Office Expenses	369,737	25,361	88,908	484,006		484,006	(77,605)	406,401		21
22	Employee Benefits & Payroll Taxes			780,675	780,675		780,675		780,675		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,953	2,953		2,953		2,953		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			64,182	64,182		64,182		64,182		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	507,321	25,361	1,058,727	1,591,409		1,591,409	(118,858)	1,472,551		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,935,390	506,172	1,363,609	5,805,171		5,805,171	(176,080)	5,629,091		29

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

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

Facility Name & ID Number Selfhelp Home Of Chicago

#0018580

Report Period Beginning:

10/01/16

Ending:

09/30/17

## 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			300,219	300,219		300,219	27,589	327,808			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,274	12,274		12,274	(232)	12,042			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			6,377	6,377		6,377	(6,377)				36
37	<b>TOTAL Ownership</b>			318,870	318,870		318,870	20,980	339,850			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		344,251	483,310	827,561		827,561		827,561			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		13	2,960	2,973		2,973		2,973			41
42	Provider Participation Fee			155,673	155,673		155,673		155,673			42
43	Other (specify):*	76,089		185,051	261,140		261,140	(261,140)				43
44	<b>TOTAL Special Cost Centers</b>	76,089	344,264	826,994	1,247,347		1,247,347	(261,140)	986,207			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	4,011,479	850,436	2,509,473	7,371,388		7,371,388	(416,240)	6,955,148			45

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



Selfhelp Home Of ChicagoID# 0018580Report Period Beginning: 10/01/16Ending: 09/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Guest Apartment Rental	\$ (1,560)	06	1
2	Misc Income	(581)	21	2
3	Non-Allowable Expense	(167,091)	43	3
4	Marketing Salary	(76,089)	43	4
5	Marketing Expense	(17,960)	43	5
6	Outreach	(1,416)	20	6
7	Public Relations	(715)	20	7
8	Special Needs	(155)	20	8
9	Support Collateral	(4,237)	20	9
10	Web Site	(3,913)	20	10
11	Loss on Sale of Equities	(514)	21	11
12	Loss retirement of asset	(6,377)	36	12
13	Non Allowable Legal	(702)	19	13
14	Additional R&M	2,114	06	14
15	Unrealized Gain/Loss	(334)	21	15
16	Capitalized R&M	(47,836)	06	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>	(327,366)		49



## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Selfhelp Home Of Chicago# 0018580

Report Period Beginning:

10/01/16

Ending:

09/30/17

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

	Operating Expenses	PAGES	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													1
2	Food Purchase	(9,940)											(9,940)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(47,282)											(47,282)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(57,222)</b>											<b>(57,222)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(702)											(702)	19
20	Fees, Subscriptions & Promotions	(40,551)											(40,551)	20
21	Clerical & General Office Expenses	(77,605)											(77,605)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(118,858)</b>											<b>(118,858)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(176,080)</b>											<b>(176,080)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Selfhelp Home Of Chicago # 0018580 Report Period Beginning: 10/01/16 Ending: 09/30/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(1,128)	28,717										27,589	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(232)											(232)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(6,377)											(6,377)	36
37	<b>TOTAL Ownership</b>	<b>(7,737)</b>	<b>28,717</b>										<b>20,980</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(261,140)											(261,140)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(261,140)</b>											<b>(261,140)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(444,957)</b>	<b>28,717</b>										<b>(416,240)</b>	<b>45</b>

Facility Name & ID Number

Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending:

09/30/17

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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		N/A		

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	30 Depreciation	\$	The Selfhelp Home Inc. - Center Division		\$ 28,717	\$ 28,717	1
2	V							2
3	V							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		\$			\$ 28,717	\$ * 28,717	14

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

**VII. RELATED PARTIES (continued)**

**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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

**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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

**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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

**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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

**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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

**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		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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





Facility Name & ID Number Selfhelp Home Of Chicago # 0018580 Report Period Beginning: 10/01/16 Ending: 09/30/17

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	See Attached								\$	1
2										2
3										3
4										4
5										5
6										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

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending: 09/30/17

**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 \_\_\_\_\_

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									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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending: 09/30/17

**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 \_\_\_\_\_

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	
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2									2
3									3
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7									7
8									8
9									9
10									10
11									11
12									12
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15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending: 09/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( \_\_\_\_\_)

Fax Number ( \_\_\_\_\_)

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.

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	
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2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending: 09/30/17

**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 \_\_\_\_\_

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	
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19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending: 09/30/17

**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 \_\_\_\_\_

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	
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending: 09/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

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	
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19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending: 09/30/17

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Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
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18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending: 09/30/17

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Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

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Fax Number ( ) \_\_\_\_\_

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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	
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15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580 Report Period Beginning: 10/01/16 Ending: 09/30/17

**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 \_\_\_\_\_  
 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	
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8									8
9									9
10									10
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16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending: 09/30/17

**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 \_\_\_\_\_

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									2
3									3
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8									8
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15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending:

09/30/17

**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>Interest Expense</b>		X	<b>Deferred Retirement Plan Benefits</b>						12,274										
11	<b>Interest Income</b>		X							(232)										
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>									12,042										
15	<b>TOTALS (line 9+line14)</b>									12,042										

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.)

\*\* 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 2016 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).		\$	3
4. Real Estate Tax accrual used for 2017 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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:	2012	8
	2013	9
	2014	10
	2015	11
	2016	12

**Facility does not pay R/E Taxes due to Not For Profit status**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.**

# 2016 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 Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
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            NO

If YES, attach an explanation and 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

**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.**

**IMPORTANT NOTICE**

**TO: Long Term Care Facilities with Real Estate Tax Rates**  
**RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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.

**2015 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 Steve Lavenda  
 TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax Applicable to Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. _____	_____	\$ _____	\$ _____
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 \_\_\_\_\_ NO

If YES, attach an explanation and 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580 Report Period Beginning:

10/01/16 Ending:

09/30/17

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 37,671 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: 87 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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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	<b>TOTALS</b>	<b>70,000</b>		<b>\$ 191,769</b>	<b>3</b>

Facility Name &amp; ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning:

10/01/16

Ending:

09/30/17

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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	72		1974	1974	\$ 822,760	\$ 28,717	50	\$ 16,455	\$ (12,262)	\$ 699,351	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1980		786		20			786	9
10	Various		1981		30,335		20			30,335	10
11	Various		1982		2,642		20			2,642	11
12	Various		1983		2,717		20			2,717	12
13	Various		1986		1,212		20			1,212	13
14	Various		1987		3,000		20			3,000	14
15	Various		1988		6,752		20			6,752	15
16	Various		1989		30,538		20			30,538	16
17	Various		1990		10,425		20			10,425	17
18	Various		1991		9,690		20			9,690	18
19	Various		1992		22,946		20			22,946	19
20	Various		1993		14,349		20			14,349	20
21	Various		1994		69,604		20			69,604	21
22	Various		1995		210,865		20			210,865	22
23	Various		1996		35,621		20	296	296	35,605	23
24	Various		1997		101,021		20	968	968	100,965	24
25	Various		1998		131,907		20	6,543	6,543	129,831	25
26	Various		1999		179,225		20	8,796	8,796	162,966	26
27	Various		2000		34,809		20	1,364	1,364	24,552	27
28	Various		2001		480,624		20	24,035	24,035	396,161	28
29	Various		2002		40,216		20	1,794	1,794	27,915	29
30	Various		2003		234,012		20	11,512	11,512	166,059	30
31	Various		2004		62,153		20	3,109	3,109	41,970	31
32	Various		2005		72,378		20	3,619	3,619	45,234	32
33	Various		2006		50,409		20	2,520	2,520	28,980	33
34	Various		2007		467,721		20	23,387	23,387	243,655	34
35	Various		2008		64,925		20	3,246	3,246	30,837	35
36	Various		2009		136,441		20	4,449	4,449	40,041	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

XI. OWNERSHIP COSTS (continued)

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

1	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 Various	2010	\$ 130,106	\$	20	\$ 6,506	\$ 6,506	\$ 51,325	37
38 Various	2011	82,478		20	4,124	4,124	28,626	38
39 Various	2012	102,706		20	6,388	6,388	36,248	39
40 Various	2013	48,558		20	2,428	2,428	11,109	40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67 Related Building Company (Pages 12F & 12G)								67
68 Related Party Allocations (Pages 12H & 12I)								68
69 Financial Statement Depreciation			300,219			(300,219)		69
70 TOTAL (lines 4 thru 69)		\$ 3,693,931	\$ 328,936		\$ 131,540	\$ (197,396)	\$ 2,717,290	70

\*\*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:

10/01/16

Ending:

09/30/17

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-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>		\$ 3,693,931	\$ 328,936		\$ 131,540	\$ (197,396)	\$ 2,717,290	1
2	4 Electronic Door Handles - 7Th & 8Th Floor (5,400)	2014	5,400		20	270	270	1,080	2
3	2 Hot Water Boilers (28,200)	2014	7,050		20	353	353	1,410	3
4	Door Closures - 7Th Floor (22,800)	2014	22,800		20	1,140	1,140	4,560	4
5	Extend Windows On Rooftop (27,000)	2014	6,750		20	338	338	1,350	5
6	Replace And Installed New Electrical Heater (6,260)	2014	1,563		20	78	78	313	6
7	Replaced And Installed New Electrical Wires And New Main Brac	2014	3,150		20	158	158	630	7
8	Repaired And Installed 30 Piping For Sprinkler System (5,200)	2014	3,900		20	195	195	780	8
9	Removed And Installed Rpz Valves And Pipe Line In Mechanical	2014	4,050		20	203	203	810	9
10	Repaired And Installed New Wall Heater, Wiring And Drain Valv	2014	4,137		20	207	207	827	10
11	Installed New Door On Roof Top (5,800)	2014	4,350		20	218	218	870	11
12	Installed New Compressor For 1St Floor Dining Room (15,498)	2014	11,623		20	581	581	2,325	12
13	8Th Floor Handler	2014	22,800		20	1,140	1,140	3,420	13
14	8Th Floor Dining Room Replace Pipes	2014	12,800		20	640	640	1,920	14
15	9Th Floor Replace Glass	2014	4,600		20	230	230	690	15
16	New Floor Drain On 7Th Floor	2014	5,870		20	294	294	881	16
17	7 Additional Skilled Beds On 6Th Floor - Repaired Signage	2015			20				17
18	Pipe, Cabling, Conduits, Sprinklers & Sink	2015			20				18
19	Plus Design/Architect/Consulting/Permit Fees	2015	2,157,796		20	107,890	107,890	323,669	19
20	Installed 6 Aluminum Closers	2015	17,100		20	855	855	2,565	20
21	Installation Of 1/4 Clear Mirror Around Outlets	2015	2,820		20	141	141	423	21
22	Alarm Systems (\$107,768.97)	2015	26,942		20	2,694	2,694	8,083	22
23	Alarm Systems (\$39,896.03)	2015	9,974		20	997	997	2,992	23
24	Replace Electric Panels (\$70,280)	2015	17,570		20	1,757	1,757	5,271	24
25	Electric Panel (\$5,500)	2015	1,375		20	138	138	413	25
26	New Roof 930 Building (\$6,800)	2015	1,700		20	170	170	510	26
27	Installed 7 Aluminum Closers 8Th Floor	2015	19,950		20	1,995	1,995	5,985	27
28	New Roof 920 Building (\$24,050)	2015	6,012		20	601	601	1,804	28
29	Removed And Installed Electrical Door Handle	2015	2,700		20	135	135	405	29
30	Installed Ceiling Tiles (\$3,666.60)	2015	2,750		20	137	137	412	30
31	Installed New Motor For Hallway Unit (\$3,788.32)	2015	2,841		20	142	142	426	31
32	Humidifier Repairs (\$3,804.36)	2015	2,853		20	143	143	428	32
33	Plumbing Repair - Installed New Pipes	2015	3,860		20	193	193	579	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,091,018	\$ 328,936		\$ 255,570	\$ (73,366)	\$ 3,093,120	34

\*\*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:

10/01/16

Ending:

09/30/17

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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>		\$ 6,091,018	\$ 328,936		\$ 255,570	\$ (73,366)	\$ 3,093,120	1
2	Repaired Chiller Wiring (\$5,241.46)	2015	3,931		20	197	197	590	2
3	Installed Floor Drain (\$5,860.23)	2015	4,395		20	220	220	659	3
4	Replaced Chilled Water Pump (\$6,307.33)	2015	4,731		20	237	237	710	4
5	Repaired And Replaced Make-Up Air Unit (\$7,239.53)	2015	5,430		20	271	271	814	5
6	Repaired Heater (\$9,263.09)	2015	6,947		20	347	347	1,042	6
7	8Th Floor C/Dining Rm-Flooring	2015	21,204		20	1,060	1,060	2,120	7
8	Roofing, All Blds	2015	4,900		20	245	245	490	8
9	9Th Air Handling Unit Replacement	2015	63,281		20	3,164	3,164	6,328	9
10	7Th & 8Th Floor Wallcovering	2015	8,934		20	447	447	893	10
11	Install New Governor Elevator-920	2015	3,768		20	188	188	377	11
12	Final Payout To 6Th Fl Additional Beds Renovation	2015	67,047		20	3,352	3,352	6,705	12
13	6Th Shower Curtains	2015	3,714		20	186	186	371	13
14	Refrigeration Repair (\$3400)	2015	2,550		20	255	255	510	14
15	Install Transfer Switch Mua 2	2015	3,116		20	156	156	312	15
16	Boiler Repair (\$5880)	2015	4,410		20	221	221	441	16
17	930 Bld Cst Iron Pipe Drain	2016	2,900		20	145	145	290	17
18	8Th Floor Corridor Carpet	2016	8,228		20	411	411	823	18
19	7Th * 8Th Wood Panel	2016	5,510		20	276	276	551	19
20	Molding And Casing 2-4 Fl	2016	2,939		20	147	147	294	20
21	9Th Tempered Glass	2016	4,250		20	213	213	425	21
22	8 Access Panels	2016	6,320		20	316	316	632	22
23	Repair Vacuum Pumps (\$6316)	2016	4,105		20	205	205	411	23
24	Fire Alarm System Repairs	2016	2,518		20	126	126	252	24
25	Repave Back Parking Lot	2016	6,891		20	345	345	345	25
26	Installed Camera System - Entrance	2016	6,997		20	350	350	350	26
27	Re-Insulated Armaflex - Rooms 402,203 And 403 (\$6322)	2016	4,109		20	205	205	205	27
28	Replaced Roof	2017	2,940		20	147	147	147	28
29	Installed New Walls, Doors - Therapy Room	2017	2,500		20	125	125	125	29
30	Replaced Hot Water Pipees - 7Th/8Th Floor Hallways	2017	2,500		20	125	125	125	30
31	Installed Ddc Controls 9Th Floor Dining Room	2017	9,623		20	481	481	481	31
32	Installed 2 New Electrical Handlers	2017	6,950		20	348	348	348	32
33	Replaced And Installed Magnetic Door Arms - 7Th/8Th Floors	2017	3,580		20	179	179	179	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,382,235	\$ 328,936		\$ 270,259	\$ (58,677)	\$ 3,121,464	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Totals from Page 12C, Carried Forward</b>		\$ 6,382,235	\$ 328,936		\$ 270,259	\$ (58,677)	\$ 3,121,464	1
2	Installed New Exhaust Fan - 6Th Floor Mech Room	2017	3,200		20	160	160	160	2
3	Installed New Compressor, Vacuum Pump - 1St Floor System (\$14	2017	9,301		20	465	465	465	3
4	Removed And Replaced Check Valve - 9Th Floor System (\$7711)	2017	5,032		20	252	252	252	4
5	Washed Out Inlet Screens, Installed Vfd - Kitchen (\$7660)	2017	4,979		20	249	249	249	5
6	Disconnected And Replaced Old Pump System - Storage Tank (\$5	2017	3,484		20	174	174	174	6
7	Disassembled/Installed New Compressor - Rae Chiller (\$5248)	2017	3,346		20	167	167	167	7
8	Replaced Fuses For Return Air Fan - 930 Hallway Unit (\$6563)	2017	4,266		20	213	213	213	8
9	Replaced Left Side Evaporator Motor/Blade - 8Th Floor Ice (\$295	2017	2,951		20	148	148	148	9
10	Replace Frequency Drive	2017	2,681		20	134	134	134	10
11	Repair Leaking Valve In 920 Air Unit	2017	2,679		20	134	134	134	11
12	Recovery Of Trane Systems	2017	5,008		20	250	250	250	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 6,429,162	\$ 328,936		\$ 272,605	\$ (56,331)	\$ 3,123,810	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 6,429,162	\$ 328,936		\$ 272,605	\$ (56,331)	\$ 3,123,810	1
2								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 6,429,162	\$ 328,936		\$ 272,605	\$ (56,331)	\$ 3,123,810	34

\*\*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:

10/01/16

Ending:

09/30/17

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	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>Building Company</b>		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 <b>Leasehold Improvements:</b>							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 <b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	1
2								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

\*\*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:

10/01/16

Ending:

09/30/17

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	1
2								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								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$	34

\*\*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:

10/01/16

Ending:

09/30/17

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 552,032	\$	\$ 55,203	\$ 55,203	10	\$ 352,520	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	595,355				10	595,355	73
74								74
75	TOTALS	\$ 1,147,387	\$	\$ 55,203	\$ 55,203		\$ 947,875	75

D. Vehicle Costs. (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				\$	\$	\$	\$		\$	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)	\$ 7,768,318	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 328,936	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 327,808	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,128)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,071,685	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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.

**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:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_ /2018                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2019                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2020                      \$ \_\_\_\_\_

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: \$ \_\_\_\_\_

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					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* 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			
		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	<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.

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	39 - 03	hrs				\$ 126,564				\$ 126,564	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				217,971				217,971	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				137,232				137,232	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					181,975			181,975	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						1,543	162,276			163,819	13
14	TOTAL				\$		\$ 483,310	\$ 344,251			\$ 827,561	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.

Facility Name & ID Number Selfhelp Home Of Chicago# 0018580Report Period Beginning: 10/01/16Ending: 09/30/17

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 09/30/17

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 411,842	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	978,568		3
4	Supply Inventory (priced at )	6,000		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	72,104		8
9	Other(specify): <u>See Attached Schedule</u>	324,542		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,793,056	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	5,298,998		15
16	Equipment, at Historical Cost	1,032,788		16
17	Accumulated Depreciation (book methods)	(2,976,055)		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): <u>See Attached Schedule</u>	63,465		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 3,419,196	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 5,212,252	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 174,467	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,222		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,811		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,001		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	148,594		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	72,104		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 479,199	\$	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>See Attached Schedule</u>	310,397		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 310,397	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 789,596	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 4,422,656	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 5,212,252	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,779,554</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Bequests</b>	<b>(257,000)</b>	<b>3</b>
<b>4</b>	<b>Net Assets Released from Restrictions</b>	<b>(198,894)</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>4,323,660</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>98,996</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>98,996</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>4,422,656</b>	<b>24</b> *

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

Facility Name & ID Number Selfhelp Home Of Chicago# 0018580Report Period Beginning: 10/01/16

Ending:

09/30/17**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		2	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,784,429	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,784,429	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	54,584	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 54,584	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	12,440	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,940	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,560	16
17	Sale of Drugs	4,275	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	82,508	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 110,723	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	490,659	24
25	Interest and Other Investment Income***	232	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 490,891	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	29,757	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 29,757	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,470,384	30

1		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,414,582	31
32	Health Care	2,799,180	32
33	General Administration	1,591,409	33
<b>B. Capital Expense</b>			
34	Ownership	318,870	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,091,674	35
36	Provider Participation Fee	155,673	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,371,388	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	98,996	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 98,996	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 468,115	44
45	Private Pay - Net Inpatient Revenue	4,038,933	45
46	Medicare - Net Inpatient Revenue	2,277,381	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 6,784,429	49

\* 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.

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

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

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

# **0018580**

Report Period Beginning:

**10/01/16**

Ending:

**09/30/17**

**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	1,956	2,080	\$ 108,343	\$ 52.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,995	31,903	1,190,423	37.31	3
4	Licensed Practical Nurses	7,205	7,663	259,966	33.92	4
5	CNAs & Orderlies	69,456	73,874	1,010,903	13.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,683	8,172	128,655	15.74	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,595	2,759	45,829	16.61	13
14	Head Cook	3,894	4,140	57,299	13.84	14
15	Cook Helpers/Assistants	24,612	26,167	315,287	12.05	15
16	Dishwashers					16
17	Maintenance Workers	7,303	7,765	141,622	18.24	17
18	Housekeepers	12,784	13,597	169,742	12.48	18
19	Laundry					19
20	Administrator	1,656	1,761	137,584	78.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,936	16,946	369,737	21.82	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)	2,084	2,216	76,089	34.34	33
34	TOTAL (lines 1 - 33)	187,159	199,043	\$ 4,011,479 *	\$ 20.15	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	282	\$ 12,984	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,848	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,330	11-03	44
45	Social Service Consultant	44	2,186	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	345	\$ 44,348		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	230	4,137	10-03	52
53	TOTAL (lines 50 - 52)	230	\$ 4,137		53

Facility Name & ID Number Selfhelp Home Of Chicago

# 0018580

Report Period Beginning: 10/01/16

Ending: 09/30/17

**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	
Marvin Rubin 10/1/16-2/10/17	Administrator	0	\$ 64,419	Workers' Compensation Insurance	\$ 199,501	IDPH License Fee	\$	
Lara Liberman 2/10/17-9/30/17	Administrator	0	73,165	Unemployment Compensation Insurance	10,720	Advertising: Employee Recruitment		
				FICA Taxes	306,878	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	241,734	Patient Background Checks		
				Employee Meals		Association Dues	10,219	
				Illinois Municipal Retirement Fund (IMRF)*				
				Drug Testing	867			
				Employee Benefits	1,500			
				Retirement Plan	19,475			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,584			Less: Public Relations Expense	( )	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 780,675	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,219	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Achieve Accreditation	Compliance		\$ 10,651			\$	Out-of-State Travel	\$
American Data	Computer Services		11,263					
Innovative Solution	IT Services		463				In-State Travel	
Marcum, LLP	Accounting		24,053					
ADP	Payroll Services		14,271				Seminar Expense	2,953
See Attached	Legal Services		10,537					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 71,238	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	( )
							TOTAL	\$ 2,953

\* Attach copy of IMRF notifications

\*\*See instructions.

**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. Leading Age \$9,618
- (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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 48,026 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 155,673  
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,940
- (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? None  
d. Have vehicle usage logs been maintained? Yes  
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: Marcum, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees