FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0015032

Facility Name: Smith Village

Address: 2320 West 113th Place (Number) Chicago (City) 60643 (Zip Code)

County: Cook

Telephone Number: (773) 474-7300 **Fax #** (773) 474-7302

HFS ID Number:

Date of Initial License for Current Owners: 5/26/1926

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Raymond Marneris, CFO **Telephone Number:** (773) 474-7350
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/11 to 6/30/12 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Raymond Marneris
(Title) Chief Financial Officer

Paid Preparer

(Signed) (Date)
(Print Name and Title) Allan B. Larson, CPA, Partner
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Ave, Suite 1800, St. Louis MO 63101
(Telephone) (314) 925-4300 Fax # (314) 925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,698	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	103	TOTALS	103	37,698	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,336	22,814	7,526	34,676	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,336	22,814	7,526	34,676	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.98%

D. How many bed-hold days during this year were paid by the Department?
0 (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)
N/A

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 5/25/1926

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 103 and days of care provided 6,576

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/12 Fiscal Year: 6/30/12

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,105,306	178,986	645,090	1,929,382		1,929,382	(1,127,588)	801,794			1
2	Food Purchase		894,950		894,950		894,950	(522,839)	372,111			2
3	Housekeeping	362,440	51,544	14,769	428,753		428,753	(378,172)	50,581			3
4	Laundry	104,367	29,108	7,604	141,079		141,079	(119,612)	21,467			4
5	Heat and Other Utilities			412,123	412,123		412,123	(349,412)	62,711			5
6	Maintenance	279,582	11,854	387,955	679,391		679,391	(580,289)	99,102			6
7	Other (specify):*											7
8	TOTAL General Services	1,851,695	1,166,442	1,467,541	4,485,678		4,485,678	(3,077,912)	1,407,766			8
	B. Health Care and Programs											
9	Medical Director			24,535	24,535		24,535		24,535			9
10	Nursing and Medical Records	2,220,399	64,767	1,441,514	3,726,680		3,726,680	(447,611)	3,279,069			10
10a	Therapy			852,638	852,638		852,638		852,638			10a
11	Activities	257,677	13,748	184,158	455,583		455,583	(387,678)	67,905			11
12	Social Services	154,460	938		155,398		155,398		155,398			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,632,536	79,453	2,502,845	5,214,834		5,214,834	(835,289)	4,379,545			16
	C. General Administration											
17	Administrative					187,868	187,868		187,868			17
18	Directors Fees											18
19	Professional Services			104,173	104,173		104,173	114,065	218,238			19
20	Dues, Fees, Subscriptions & Promotions			32,467	32,467		32,467	4,197	36,664			20
21	Clerical & General Office Expenses	378,307	22,010	1,756,484	2,156,801	(187,868)	1,968,933	(763,400)	1,205,533			21
22	Employee Benefits & Payroll Taxes			1,063,251	1,063,251		1,063,251	137,499	1,200,750			22
23	Inservice Training & Education			402	402		402		402			23
24	Travel and Seminar			23,057	23,057		23,057	21,882	44,939			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			124,375	124,375		124,375	(80,067)	44,308			26
27	Other (specify):*							(10,185)	(10,185)			27
28	TOTAL General Administration	378,307	22,010	3,104,209	3,504,526		3,504,526	(576,009)	2,928,517			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,862,538	1,267,905	7,074,595	13,205,038		13,205,038	(4,489,210)	8,715,828			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 Smith Village #0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			2,189,138	2,189,138		2,189,138	(1,812,485)	376,653			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,152,911	2,152,911		2,152,911	(1,825,313)	327,598			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,692	29,692		29,692	(25,174)	4,518			35
36	Other (specify):*											36
37	**TOTAL Ownership**			4,371,741	4,371,741		4,371,741	(3,662,972)	708,769			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			414,538	414,538		414,538		414,538			39
40	Barber and Beauty Shops			55,828	55,828		55,828	(58,100)	(2,272)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			264,234	264,234		264,234		264,234			42
43	Other (specify):* **Marketing**	120,335	3,908	708,077	832,320		832,320	(828,412)	3,908			43
44	**TOTAL Special Cost Centers**	120,335	3,908	1,442,677	1,566,920		1,566,920	(886,512)	680,408			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,982,873	1,271,813	12,889,013	19,143,699		19,143,699	(9,038,694)	10,105,005			45

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(39,957)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				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	(305)	21		18
19	Entertainment				19
20	Contributions	(1,614)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(76,707)	21		24
25	Fund Raising, Advertising and Promotional				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 Supplemental Schedule	(8,748,730)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (8,867,313)		$	30

BHF USE ONLY								
48		49		50		51		52

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 Amount	2 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)	(171,381)	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (171,381)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (9,038,694)		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 Yes	2 No	3 Amount	4 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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Smith Village

ID# 0015032

Report Period Beginning: 7/1/11

Ending: 6/30/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL dietary costs	$ (1,127,588)	1	1
2	AL/IL food purchases	(523,035)	2	2
3	Guest Room Income	(14,660)	3	3
4	AL/IL housekeeping	(363,512)	3	4
5	AL/IL laundry	(119,612)	4	5
6	AL/IL heat & other utilities	(349,412)	5	6
7	Maintenance income	(4,278)	6	7
8	AL/IL maintenance	(576,011)	6	8
9	AL/IL nursing costs	(447,611)	10	9
10	Life Enrichment (activities) income	(1,419)	11	10
11	AL/IL activities	(386,259)	11	11
12	AL/IL Employee Recruitment	(772)	20	12
13	AL/IL office & clerical	(19,811)	21	13
14	Marketing employee benefits	(16,637)	22	14
15	AL/IL nursing & activities emp benefits	(65,486)	22	15
16	AL/IL insurance	(105,449)	26	16
17	Bank fees	(5,595)	27	17
18	Other taxes and fees	(4,590)	27	18
19	Apt depreciation	(23,966)	30	19
20	AL/IL & Apt depreciation	(1,856,028)	30	20
21	AL/IL bond interest	(1,825,313)	32	21
22	AL/IL Equipment/Vehicle Rent	(25,174)	35	22
23	Beauty shop income	(58,100)	40	23
24	Apt bldg expenses & utilities	(56,857)	43	24
25	Marketing wages	(120,335)	43	25
26	Misc marketing expenses	(651,220)	43	26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,748,730)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Village # 0015032 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	(1,127,588)	0	0	0	0	0	0	0	0	0	0	(1,127,588)	1
2	Food Purchase	(523,035)	196	0	0	0	0	0	0	0	0	0	(522,839)	2
3	Housekeeping	(378,172)	0	0	0	0	0	0	0	0	0	0	(378,172)	3
4	Laundry	(119,612)	0	0	0	0	0	0	0	0	0	0	(119,612)	4
5	Heat and Other Utilities	(349,412)	0	0	0	0	0	0	0	0	0	0	(349,412)	5
6	Maintenance	(580,289)	0	0	0	0	0	0	0	0	0	0	(580,289)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,078,108)	196	0	0	0	0	0	0	0	0	0	(3,077,912)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(447,611)	0	0	0	0	0	0	0	0	0	0	(447,611)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(387,678)	0	0	0	0	0	0	0	0	0	0	(387,678)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(835,289)	0	0	0	0	0	0	0	0	0	0	(835,289)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	114,065	0	0	0	0	0	0	0	0	0	114,065	19
20	Fees, Subscriptions & Promotions	(772)	4,969	0	0	0	0	0	0	0	0	0	4,197	20
21	Clerical & General Office Expenses	(138,394)	(625,006)	0	0	0	0	0	0	0	0	0	(763,400)	21
22	Employee Benefits & Payroll Taxes	(82,123)	219,622	0	0	0	0	0	0	0	0	0	137,499	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	21,882	0	0	0	0	0	0	0	0	0	21,882	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(105,449)	25,382	0	0	0	0	0	0	0	0	0	(80,067)	26
27	Other (specify):*	(10,185)	0	0	0	0	0	0	0	0	0	0	(10,185)	27
28	**TOTAL General Administration**	(336,923)	(239,086)	0	0	0	0	0	0	0	0	0	(576,009)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,250,320)	(238,890)	0	0	0	0	0	0	0	0	0	(4,489,210)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Village # 0015032 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,879,994)	67,509	0	0	0	0	0	0	0	0	0	(1,812,485)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,825,313)	0	0	0	0	0	0	0	0	0	0	(1,825,313)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(25,174)	0	0	0	0	0	0	0	0	0	0	(25,174)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,730,481)	67,509	0	0	0	0	0	0	0	0	0	(3,662,972)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(58,100)	0	0	0	0	0	0	0	0	0	0	(58,100)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(828,412)	0	0	0	0	0	0	0	0	0	0	(828,412)	43
44	TOTAL Special Cost Centers	(886,512)	0	0	0	0	0	0	0	0	0	0	(886,512)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(8,867,313)	(171,381)	0	0	0	0	0	0	0	0	0	(9,038,694)	45

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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
		Smith Crossing	Orland Park	Smith Senior Living	Chicago	Home Office

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food purchases	$	Smith Senior Living		$ 196	$ 196	1
2	V	19	Professional Services		Smith Senior Living		114,065	114,065	2
3	V	20	Fees, Subscriptions		Smith Senior Living		4,969	4,969	3
4	V	21	Clerical & General Office Exp		Smith Senior Living		1,079,708	1,079,708	4
5	V	22	PR Taxes & Employee Benefits		Smith Senior Living		219,622	219,622	5
6	V	24	Travel and Seminar		Smith Senior Living		21,882	21,882	6
7	V	26	Insurance		Smith Senior Living		25,382	25,382	7
8	V	30	Depreciation		Smith Senior Living		67,509	67,509	8
9	V								9
10	V								10
11	V								11
12	V	21	Corporate Administration	1,704,714				(1,704,714)	12
13	V								13
14	Total			$ 1,704,714			$ 1,533,333	$ * (171,381)	14

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Thomas E. Chomicz	Board Member	Trustee of the	None	1,641			Legal Services	$ 788	19.3	1
2			Board and Partner		Smith Crossing						2
3			at Quarles & Brady								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 788		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 Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 [x] NO [ ]

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

Name of Related Organization: Smith Senior Living
Street Address: 2320 West 113th Place
City / State / Zip Code: Chicago, IL 60643
Phone Number: ((773) 474-7350
Fax Number: ((773) 474-7352

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food purchases	Direct Cost	30,947,925	2	$ 301	$	19,282,395	$ 188	1
2	19	Professional Services	Direct Cost	30,947,925	2	174,843		19,282,395	108,938	2
3	20	Fees, Subscriptions	Direct Cost	30,947,925	2	7,616		19,282,395	4,745	3
4	21	Clerical & General Office Exp	Direct Cost	30,947,925	2	1,655,012	1,432,481	19,282,395	1,031,171	4
5	22	PR Taxes & Employee Benefits	Direct Cost	30,947,925	2	336,643		19,282,395	209,749	5
6	24	Travel and Seminar	Direct Cost	30,947,925	2	33,541		19,282,395	20,898	6
7	26	Insurance	Direct Cost	30,947,925	2	38,907		19,282,395	24,241	7
8	30	Depreciation	Direct Cost	30,947,925	2	103,481		19,282,395	64,475	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					$ 2,350,344	$ 1,432,481		$ 1,464,405	25

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	IHFA Series 2005A		X	Bond Refin & Construction	Varies	12/2005	$ 34,305,000	$ 33,620,000	11/2035	0.0604	$ 2,035,074	1
2	IHFA Series 2005B-1		X	Construction	Varies	12/2005	5,000,000	5,000,000	11/2035	0.0500	250,000	2
3	IHFA Series 2005B-2		X	Construction	Varies	12/2005	2,500,000		11/2010	0.0500	(113,387)	3
4	IHFA Series 2005C		X	Construction	Varies	12/2005	20,000,000		11/2010	Variable		4
5												5
	Working Capital											
6	Smith Senior Living	X		Working Capital		6/30/2010	2,004,303	2,004,303	6/30/2020	0.0238		6
7	Smith Senior Living	X		Payoff IHFA Series 2005B-2		9/30/2010	2,500,000	728,153	9/30/2014	0.0250	(18,776)	7
8												8
9	TOTAL Facility Related						$ 66,309,303	$ 41,352,456			$ 2,152,911	9
	B. Non-Facility Related*											
10	Less AL/IL portion of interest expense											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 66,309,303	$ 41,352,456			$ 2,152,911	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ NA** **Line #** _____

*** 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.)**

Facility Name & ID Number Smith Village **#** 0015032 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2012 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:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Smith Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015032

CONTACT PERSON REGARDING THIS REPORT Raymond Marneris, CFO

TELEPHONE (773) 474-7350 FAX #: (773) 474-7352

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	NA		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,084 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (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? [X] (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).

Smith Village - 11365 S. Western Avenue, Chicago, IL - Apartments - Costs adjusted out on page 5
Smith Village - 2315 W. 112th Place, Smith Village Assisted Living, 82 Units, 65,000 Square Feet - Costs adjusted out on page 5
Smith Village - 2320 West 113th Place, Smith Village Independent Living, 152 Units, 268,073 Square feet - Costs adjusted out on page 5

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land	247,516	Pre 1994	$ 649,404	1
2					2
3	TOTALS	247,516		$ 649,404	3

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	103			1992	$ 4,868,578	$	35	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Various			2003	43,522		Various				10
11	Various			2004	10,236		Various				11
12	Various			2005	69,752		Various				12
13	Various			2006	2,656		Various				13
14	Various			2007	270,111		Various				14
15	Thyssenkrupp Elevator - Wandering System			2008	3,457		10				15
16	Red Hawk - Security			2008	4,526		10				16
17	Thyssenkrupp Elevator - Recall			2008	11,554		5				17
18	Chatham Rug - carpet			2008	1,025		10				18
19	Chatham Rug - carpet			2008	917		10				19
20	City Service Electrical, Inc. - install conduit & wiring			2008	5,100		10				20
21	Thyssenkrupp - elevator upgrade			2008	8,286		10				21
22	Edwards Services Div - drawings & submittals			2008	2,817		10				22
23	Edwards Services Div - fire project & parts			2008	2,909		10				23
24	Thyssenkrupp - smoke detector			2008	2,142		10				24
25	Edwards Services Div - inspection			2008	1,786		10				25
26	Thyssenkrupp - smoke detector			2008	14,821		10				26
27	Chatham Rug - carpet credit			2008	(1,025)		10				27
28	The Geo Group - wall safes			2009	2,340		10				28
29	Chatham Rug - carpet			2009	583		10				29
30	Red Hawk - Security installation			2009	7,000		10				30
31	Wall Products Inc. - wall safes			2009	5,113		15				31
32	Chatham Rug - carpet			2009	611		5				32
33	Red Hawk - installation of security cameras			2009	8,553		10				33
34	Chatham Rug - carpet			2009	568		5				34
35	Sharlen Electric Company - hand dryers and labor			2009	4,438		5				35
36	Red Hawk - Security Relocation of Access Control Equipment			2009	1,450		10				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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	
37	Creative Carpet	2009	$ 12,812	$	5	$	$	$	37
38	C J Erickson Plumbing	2009	5,750		15				38
39	Creative Carpet	2010	26,442		5				39
40	Johanson - Carpeting	2010	113,263		5				40
41	Johanson - Ceiling Tiles	2010	146,000		8				41
42	Johanson - Ceramic Tiling	2010	115,193		20				42
43	Johanson - Doors & Frames	2010	90,237		15				43
44	Johanson - Electrical	2010	258,533		20				44
45	Johanson - Elevator	2010	9,950		20				45
46	Johanson - Fire Security	2010	4,500		10				46
47	Johanson - HVAC	2010	13,557		15				47
48	Johanson - Plumbing	2010	129,583		25				48
49	Johanson - Resilient Floor	2010	107,896		20				49
50	Johanson - General Improvements Construction Costs	2010	1,001,585		15				50
51	Johanson - Smith U	2010	2,134		15				51
52	Johanson - Wellness Center	2010	54,465		15				52
53	City Service Electric - Emergency Power	2010	3,300		10				53
54	Install Pipe and Wire Devices	2010	1,086		18				54
55	Tryslides	2010	5,578		10				55
56	Elevator Security System	2010	9,745		20				56
57	Johanson - Electrical	2010	9,574		14				57
58	Johanson - General Improvements Construction Costs	2010	32,529		15				58
59	Johanson - General Improvements Construction Costs	2010	70,962		15				59
60	Signage	2010	3,128		5				60
61	Signage	2011	7,356		7				61
62	Flooring	2011	11,832		10				62
63	Platform and handrails	2011	7,840		20				63
64	Carpeting	2011	44,916		5				64
65	IT OFC Remodel	2012	18,672		5				65
66	Carpeting	2012	74,813		5				66
67	Cabinets	2012	21,692		10				67
68	Total Building & Building Improvements Depreciation Expense			1,843,142		1,843,142		5,476,771	68
69	Home Office Allocated Depreciation Expense (from Page 8)								69
70	TOTAL (lines 4 thru 69)		$ 7,768,749	$ 1,843,142		$ 1,843,142	$	$ 5,476,771	70

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	$ 2,749,046	$ 301,930	$ 301,930	$	7	$ 847,867	71
72	Current Year Purchases	265,715	12,694	12,694		7	3,350	72
73	Fully Depreciated Assets	317,037				7	317,037	73
74								74
75	TOTALS	$ 3,331,798	$ 314,624	$ 314,624	$		$ 1,168,254	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	Nursing Facility	2000 Ford Goshen Bus	2000	$ 45,104	$ 3,007	$ 3,007	$	15	$ 36,084	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905	2,191	2,191		10	21,905	77
78	Nursing Facility	2005 Chevy Impala	2005	17,756	1,776	1,776		10	12,873	78
79	Nursing Facility	Trailer	2005	4,326	432	432		10	2,847	79
80	TOTALS			$ 89,091	$ 7,406	$ 7,406	$		$ 73,709	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)	$ 11,839,042	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,165,172	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 2,165,172	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,718,734	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	Land - Apts, Oakley St, Morrison	$ 553,192	$	$	86
87	Building - Apartments	459,415	25,244	166,745	87
88	Building Improvements Apartments	304,852	23,966	171,913	88
89	Furnishings & Equip - Apartments	84,048	5,560	44,435	89
90	Smith Village North Building	58,000,838	1,337,487	5,586,145	90
91	TOTALS	$ 59,402,345	$ 1,392,257	$ 5,969,238	91

G. Construction-in-Progress

	Description	Cost	
92	NA	$	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.

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
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	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: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ NA Description: NA
    (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	TOTAL		$	$	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.

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

CNA's have received training and certification prior to being hired with Smith Village.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10.3	hrs	$	5,134	$ 405,812	$	5,134	$ 405,812	1
2	Licensed Speech and Language Development Therapist	10.3	hrs		582	58,741		582	58,741	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.3	hrs		5,015	388,085		5,015	388,085	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			$	10,731	$ 852,638	$	10,731	$ 852,638	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.

STATE OF ILLINOIS

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 978,615	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 93,495)	918,630		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	3,440,222		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	78,461		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,415,928	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,674,140		13
14	Buildings, at Historical Cost	66,095,206		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,474,470		16
17	Accumulated Depreciation (book methods)	(13,013,345)		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): See Supplemental Schedule	8,487,739		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 66,718,210	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 72,134,138	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,000,377	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	404,810		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	291,881		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	993,189		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,690,257	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	38,867,322		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	See Supplemental Schedule	28,792,118		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 67,659,440	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 71,349,697	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 784,441	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 72,134,138	$	48

*(See instructions.)

XV. BALANCE SHEET - Supplemental Schedule

Line 23 - Other Assets

Description	Amount
Assets limited as to use	4,781,968
Assets held in perpetual trust	62,383
Bond financing costs	1,141,053
Cost of acquiring continuin care contracts	1,774,182
Due to/from related party	728,153
	8,487,739

Line 36 - Other Current Liabilities

Description	Amount
Resident Credit Balances	256,444
Refundable reservation deposit	550,767
Deferred Revenue from non refundable entrance fee	184,150
Other Current Liabilities	1,828
	993,189

Line 44 - Other Long Term Liabilities

Description	Amount
Notes Payable to affiliate - SSL	2,065,330
Refundable entrance fees	21,603,327
Deferred Revenue from non-refundable entrance fee	1,354,108
Due to/from Related Deferred Mgt Fees	3,769,353
	28,792,118

Facility Name & ID Number Smith Village **#** 0015032 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,285,161	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,285,161	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(500,720)	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)**	$ (500,720)	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)**	$ 784,441	24 *

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,666,208	1
2	Discounts and Allowances for all Levels	(966,067)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,700,141	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,413,743	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,413,743	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	58,100	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	70,679	15
16	Rental of Facility Space	74,889	16
17	Sale of Drugs	266,022	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,019	19
20	Radiology and X-Ray	28,977	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 522,686	23
	D. Non-Operating Revenue		
24	Contributions	578,840	24
25	Interest and Other Investment Income***	293,514	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 872,354	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	134,055	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 134,055	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 18,642,979	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,499,143	31
32	Health Care	4,606,853	32
33	General Administration	3,977,667	33
	B. Capital Expense		
34	Ownership	4,493,116	34
	C. Ancillary Expense		
35	Special Cost Centers	470,366	35
36	Provider Participation Fee	264,234	36
	D. Other Expenses (specify):		
37	Marketing	832,320	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 19,143,699	40
41	**Income before Income Taxes (line 30 minus line 40)****	(500,720)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (500,720)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 582,937	44
45	Private Pay - Net Inpatient Revenue	11,917,494	45
46	Medicare - Net Inpatient Revenue	3,109,083	46
47	Other-(specify) Hospice	89,034	47
48	Other-(specify) Other	1,593	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,700,141	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.**

XVII. INCOME STATEMENT - Detail of Other Revenue, Line 28

Description	Amount
Miscellaneous income	7,188
Life Enrichment (activities) income	1,419
Dining Services income	121,170
Maintenance charge-backs	4,278
	$ 134,055

Line 25 Interest and Other Investment Income

Income reported on this line is related to unrealized gain/loss and restricted funds, and therefore, has not been offset against interest expense reported on Schedule V, line 32.

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	1,980	$ 116,580	$ 58.88	1
2	Assistant Director of Nursing	2,080	1,987	77,095	38.80	2
3	Registered Nurses	8,001	7,939	238,733	30.07	3
4	Licensed Practical Nurses	9,395	9,337	234,291	25.09	4
5	CNAs & Orderlies	117,264	116,771	1,414,148	12.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	1,987	53,121	26.73	9
10	Activity Assistants	20,288	18,626	223,676	12.01	10
11	Social Service Workers	6,024	5,962	156,186	26.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	28,577	25,586	374,324	14.63	14
15	Cook Helpers/Assistants	68,882	68,401	696,757	10.19	15
16	Dishwashers					16
17	Maintenance Workers	12,240	12,128	278,232	22.94	17
18	Housekeepers	33,196	33,065	361,328	10.93	18
19	Laundry	10,175	10,135	104,262	10.29	19
20	Administrator	2,080	1,987	122,199	61.50	20
21	Assistant Administrator	2,080	1,980	65,669	33.17	21
22	Other Administrative	10,921	10,882	142,168	13.06	22
23	Office Manager					23
24	Clerical					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 C: Other	10,277	10,218	171,595	16.79	32
33	Other(specify) Marketing	5,774	5,692	152,509	26.79	33
34	TOTAL (lines 1 - 33)	351,414	344,663	$ 4,982,873 *	$ 14.46	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				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	127	6,653	11.3	44
45	Social Service Consultant	11	645	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	138	$ 7,298		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	12	$ 604	10.3	50
51	Licensed Practical Nurses	10	318	10.3	51
52	Certified Nurse Assistants/Aides	8	152	10.3	52
53	TOTAL (lines 50 - 52)	30	$ 1,074		53

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kevin McGee	Executive Director	0	$ 122,199
Amanda Mauceri	Associate Executive Director	0	65,669
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 187,868

B. Administrative - Other

Description	Amount
NA	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Probe	Legal	$ 360
Quarles & Brady LLP	Legal	20,014
Polsinelli Shughart PC	Legal	2,155
Hinshaw & Culbertson LLP	Legal	47,905
Paylocity	Payroll Service	14,632
SB&A	Marketing Audit	12,785
Prove	Investigation	6,322
Add: Home Office allocation		114,065
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 218,238

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 147,195
Unemployment Compensation Insurance	
FICA Taxes	366,850
Employee Health Insurance	426,376
Employee Meals	49,378
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	9,522
Life Insurance	3,639
Pension/401K Match	74,250
PTO Used / Not Paid	(16,968)
Tuition Reimbursement	3,009
Less: AL/IL & Marketing Employee Benefits	(82,123)
Add: Home Office employee benefits	219,622
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,200,750

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NA		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,521
Health Care Worker Background Check	13,696
(Indicate # of checks performed)	
Patient Background Checks	
Dues & memberships	14,058
Subscriptions	3,192
Remove AL/IL costs	(772)
Add: Home Office allocation	4,969
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 36,664

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,290
Related meals	1,872
Seminar Expense	15,895
Remove AL/IL seminar & related costs	0
Add: Home Office allocation	21,882
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 44,939

* Attach copy of IMRF notifications

**See instructions.

Legal Expense Summary

HINSHAW & CULBERTSON			
	10/31/2011	Employee issues/ Analysis of collective bargining proposals	$15,085.63
	12/15/2011		$29,772.28
	2/29/2012		$3,047.31
POLSINELLI SHUGHART	7/31/2011		$512.50
	8/31/2011		$671.50
	2/29/2012	Resident issues/general/rejection of medical orders	$971.67
PROBE	10/31/2011		$360.00
QUARLES & BRADY	3/31/2012	Smith Village Trademark	$788.50
	4/30/2012	Meeting regarding Clare Oaks acquistion	353.25
	5/31/2012	Clare Oaks acquistion/ground lease draft amendment/court approval of purchase in bartlett/Asset purchase agreement and ehtical directives	16,333.85
	6/22/2012	Resolve to withdraw from the letter of intent	2,537.18
			$70,433.67

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/11 Ending: 6/30/12

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								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	NA		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Smith Village **#** 0015032 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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. **Life Services Network & AAHSA $12,072**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **NA**

(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? **7-10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **37,427** 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. **NA**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **264,234**
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. $ **49,378** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(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. $ **NA**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
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. $ **NA**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **CliftonLarsonAllen 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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.