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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0015032

Facility Name: Smith Village

Address: 2320 W 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
[ ]	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 07/01/2013 to 06/30/2014 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) Deborah Freeland, Principal

(Firm Name & Address) CliftonLarsonAllen LLP, 9339 Priority Way West Drive, Indianapolis, IN 46240

(Telephone) (317) 569-6230 Fax # (317-574-9707

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: 07/01/2013 Ending: 06/30/2014

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 7/1/2012

	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)	100	36,500	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	100	36,500	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	3,612	22,651	6,591	32,854	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	3,612	22,651	6,591	32,854	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.01%

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 05/25/1926

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 6,591

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: 6/30/2014 Fiscal Year: 6/30/2014

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	1,076,029	143,499	577,707	1,797,235		1,797,235	(1,202,417)	594,818			1
2	Food Purchase		969,673		969,673		969,673	(819,532)	150,141			2
3	Housekeeping	373,807	54,477	16,109	444,393		444,393	(376,772)	67,621			3
4	Laundry	113,757	32,339	483	146,579		146,579	(124,275)	22,304			4
5	Heat and Other Utilities			478,787	478,787		478,787	(405,932)	72,855			5
6	Maintenance	278,179	18,593	514,231	811,003		811,003	(713,928)	97,075			6
7	Other (specify):*											7
8	TOTAL General Services	1,841,772	1,218,581	1,587,317	4,647,670		4,647,670	(3,642,856)	1,004,814			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,836,834	119,036	2,432,244	4,388,114		4,388,114	(685,560)	3,702,554			10
10a	Therapy			842,862	842,862		842,862		842,862			10a
11	Activities	292,728	10,541	204,234	507,503		507,503	(433,254)	74,249			11
12	Social Services	163,407		1,700	165,107		165,107		165,107			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,292,969	129,577	3,505,040	5,927,586		5,927,586	(1,118,814)	4,808,772			16
	C. General Administration											
17	Administrative					195,847	195,847		195,847			17
18	Directors Fees											18
19	Professional Services			164,316	164,316		164,316	60,428	224,744			19
20	Dues, Fees, Subscriptions & Promotions			41,023	41,023		41,023	(175)	40,848			20
21	Clerical & General Office Expenses	405,263	21,705	1,734,385	2,161,353	(195,847)	1,965,506	(346,754)	1,618,752			21
22	Employee Benefits & Payroll Taxes			1,122,103	1,122,103		1,122,103	396,784	1,518,887			22
23	Inservice Training & Education			390	390		390		390			23
24	Travel and Seminar			16,728	16,728		16,728	21,179	37,907			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			155,210	155,210		155,210	(98,460)	56,750			26
27	Other (specify):*											27
28	TOTAL General Administration	405,263	21,705	3,234,155	3,661,123		3,661,123	33,002	3,694,125			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,540,004	1,369,863	8,326,512	14,236,379		14,236,379	(4,728,668)	9,507,711			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.

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule

		To Line	From Line
Reclassify administrator wages	$ 195,847	17	21

Facility Name & ID Number Smith Village #0015032 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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			2,273,604	2,273,604		2,273,604	(1,585,930)	687,674			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,299,634	2,299,634		2,299,634	(2,390,636)	(91,002)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,944	24,944		24,944	(21,148)	3,796			35
36	Other (specify):*											36
37	**TOTAL Ownership**			4,598,182	4,598,182		4,598,182	(3,997,714)	600,468			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			461,384	461,384		461,384		461,384			39
40	Barber and Beauty Shops			63,142	63,142		63,142	(63,150)	(8)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			212,315	212,315		212,315		212,315			42
43	Other (specify):* **Mareketing**	165,897	2,391	1,022,722	1,191,010		1,191,010	(1,022,722)	168,288			43
44	**TOTAL Special Cost Centers**	165,897	2,391	1,759,563	1,927,851		1,927,851	(1,085,872)	841,979			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,705,901	1,372,254	14,684,257	20,762,412		20,762,412	(9,812,254)	10,950,158			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: 07/01/2013 Ending: 06/30/2014

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(174,586)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,983)	21		5
6	Rented Facility Space	(40,083)	30		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	(440,926)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(63,150)	40		16
17	Non-Care Related Fees	(25,899)	6		17
18	Fines and Penalties	(432)	6		18
19	Entertainment				19
20	Contributions	(2,850)	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	(85,255)	21		24
25	Fund Raising, Advertising and Promotional	(1,022,722)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(65,715)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(8,364,570)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,289,171)		$	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)	476,917	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 476,917		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (9,812,254)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					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: 07/01/2013

Ending: 06/30/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL dietary costs	$ (1,202,417)	1	1
2	AL/IL food purchases	(648,747)	2	2
3	AL/IL housekeeping	(376,772)	3	3
4	AL/IL laundry	(124,275)	4	4
5	AL/IL heat & other utilities	(405,932)	5	5
6	AL/IL maintenance	(687,597)	6	6
7	AL/IL nursing costs	(685,560)	10	7
8	Life Enrichment (activities) income	(2,975)	11	8
9	AL/IL activities	(430,279)	11	9
10	AL/IL Employee Recruitment	(175)	20	10
11	AL/IL office & clerical	(19,811)	21	11
12	AL/IL nursing & activities emp benefits	(53,821)	22	12
13	AL/IL insurance	(131,592)	26	13
14	AL/IL & Apt depreciation	(1,623,759)	30	14
15	AL/IL bond interest	(1,949,710)	32	15
16	AL/IL Equipment/Vehicle Rent	(21,148)	35	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,364,570)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Village # 0015032 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,202,417)	0	0	0	0	0	0	0	0	0	0	(1,202,417)	1
2	Food Purchase	(823,333)	3,801	0	0	0	0	0	0	0	0	0	(819,532)	2
3	Housekeeping	(376,772)	0	0	0	0	0	0	0	0	0	0	(376,772)	3
4	Laundry	(124,275)	0	0	0	0	0	0	0	0	0	0	(124,275)	4
5	Heat and Other Utilities	(405,932)	0	0	0	0	0	0	0	0	0	0	(405,932)	5
6	Maintenance	(713,928)	0	0	0	0	0	0	0	0	0	0	(713,928)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,646,657)	3,801	0	0	0	0	0	0	0	0	0	(3,642,856)	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	(685,560)	0	0	0	0	0	0	0	0	0	0	(685,560)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(433,254)	0	0	0	0	0	0	0	0	0	0	(433,254)	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**	(1,118,814)	0	0	0	0	0	0	0	0	0	0	(1,118,814)	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	60,428	0	0	0	0	0	0	0	0	0	60,428	19
20	Fees, Subscriptions & Promotions	(175)	0	0	0	0	0	0	0	0	0	0	(175)	20
21	Clerical & General Office Expenses	(176,614)	(170,140)	0	0	0	0	0	0	0	0	0	(346,754)	21
22	Employee Benefits & Payroll Taxes	(53,821)	450,605	0	0	0	0	0	0	0	0	0	396,784	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	21,179	0	0	0	0	0	0	0	0	0	21,179	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(131,592)	33,132	0	0	0	0	0	0	0	0	0	(98,460)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(362,202)	395,204	0	0	0	0	0	0	0	0	0	33,002	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,127,673)	399,005	0	0	0	0	0	0	0	0	0	(4,728,668)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Village # 0015032 **Report Period Beginning:** 07/01/2013 **Ending:** 06/30/2014

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,663,842)	77,912	0	0	0	0	0	0	0	0	0	(1,585,930)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,390,636)	0	0	0	0	0	0	0	0	0	0	(2,390,636)	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	(21,148)	0	0	0	0	0	0	0	0	0	0	(21,148)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,075,626)	77,912	0	0	0	0	0	0	0	0	0	(3,997,714)	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	(63,150)	0	0	0	0	0	0	0	0	0	0	(63,150)	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):*	(1,022,722)	0	0	0	0	0	0	0	0	0	0	(1,022,722)	43
44	**TOTAL Special Cost Centers**	(1,085,872)	0	0	0	0	0	0	0	0	0	0	(1,085,872)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,289,171)	476,917	0	0	0	0	0	0	0	0	0	(9,812,254)	45

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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. ☐ 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		$ 3,801	$ 3,801	1
2	V	19	Professional Services		Smith Senior Living		60,428	60,428	2
3	V	21	Clerical & General Office Exp		Smith Senior Living		1,327,097	1,327,097	3
4	V	22	PR Taxes & Employee Benefits		Smith Senior Living		450,605	450,605	4
5	V	24	Travel & Seminar		Smith Senior Living		21,179	21,179	5
6	V	26	Insurance		Smith Senior Living		33,132	33,132	6
7	V	30	Depreciation		Smith Senior Living		77,912	77,912	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V	21	Corporate Administration	1,497,237				(1,497,237)	12
13	V								13
14	Total			$ 1,497,237			$ 1,974,154	$ * 476,917	14

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	N/A								$		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 Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 6/30/2014

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	$ 5,837	$	19,282,395	$ 3,637	1
2	19	Professional Services	Direct Cost	30,947,925	2	92,627		19,282,395	57,712	2
3	21	Clerical & General Office Exp	Direct Cost	30,947,925	2	2,034,218	1,565,980	19,282,395	1,267,439	3
4	22	PR Taxes & Employee Benefits	Direct Cost	30,947,925	2	690,701		19,282,395	430,348	4
5	24	Travel & Seminar	Direct Cost	30,947,925	2	32,463		19,282,395	20,226	5
6	26	Insurance	Direct Cost	30,947,925	2	50,786		19,282,395	31,643	6
7	30	Depreciation	Direct Cost	30,947,925	2	119,427		19,282,395	74,410	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,026,059	$ 1,565,980		$ 1,885,415	25

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$ 32,140,000	11/2035	0.0604	$ 2,049,634	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		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		6/30/2020	0.0238		6
7	Smith Senior Living	X		Payoff IHFA Series 2005B-2		9/30/2010	2,500,000		9/30/2014	0.0250		7
8												8
9	TOTAL Facility Related						$ 66,309,303	$ 37,140,000			$ 2,299,634	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 66,309,303	$ 37,140,000			$ 2,299,634	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** **N/A** **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:** 07/01/2013 **Ending:** 06/30/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:		
	2009	8
	2010	9
	2011	10
	2012	11
	2013	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 07/01/2013 Ending: 06/30/2014

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	Pre1994	$ 649,404	1
2					2
3	TOTALS	247,516		$ 649,404	3

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	100			1992	$ 4,868,578	$	35	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2003	43,522		Various				9
10	Various			2004	54,202		Various				10
11	Various			2005	69,752		Various				11
12	Various			2006	2,656		Various				12
13	Various			2007	258,065		Various				13
14	Thyssenkrupp Elevator - Wandering System			2008	3,457		10				14
15	Red Hawk - Security			2008	4,526		10				15
16	Thyssenkrupp Elevator - Recall			2008	11,554		5				16
17	Chatham Rug - carpet			2008	1,025		10				17
18	Chatham Rug - carpet			2008	917		10				18
19	City Service Electrical, Inc. - install conduit & wiring			2008	5,100		10				19
20	Thyssenkrupp - elevator upgrade			2008	8,286		10				20
21	Edwards Services Div - drawings & submittals			2008	2,817		10				21
22	Edwards Services Div - fire project & parts			2008	2,909		10				22
23	Thyssenkrupp - smoke detector			2008	2,142		10				23
24	Edwards Services Div - inspection			2008	1,786		10				24
25	Thyssenkrupp - smoke detector			2008	14,821		10				25
26	Chatham Rug - carpet credit			2008	(1,025)		10				26
27	The Geo Group - wall safes			2009	2,340		10				27
28	Chatham Rug - carpet			2009	583		10				28
29	Red Hawk - Security installation			2009	7,000		10				29
30	Wall Products Inc. - wall safes			2009	5,113		15				30
31	Chatham Rug - carpet			2009	611		5				31
32	Red Hawk - installation of security cameras			2009	8,553		10				32
33	Chatham Rug - carpet			2009	568		5				33
34	Sharlen Electric Company - hand dryers and labor			2009	4,438		5				34
35	Red Hawk - Security Relocation of Access Control Equipment			2009	1,450		10				35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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 Replaced marketplace flooring	2011	11,832		10				62
63	Platform and handrails	2011	7,840		20				63
64	Carpeting 14 AL units, 19 IL units, Dining area	2011	44,916		5				64
65	IT OFC Remodel	2012	18,672		5				65
66	Carpeting 27 AL units, 29 IL units, Cafeteria	2012	74,813		5				66
67	Cabinets in AL kitchen	2012	21,692		10				67
68	Nurses Station Remodel	2013	429		15				68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,801,098	$		$	$	$	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: 07/01/2013 Ending: 06/30/2014

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	Totals from Page 12A, Carried Forward		$ 7,801,098	$		$	$	$	1
2	Cabinetry - Charting	2012	3,920		15				2
3	Johanson Courtyard	2012	12,300		15				3
4	Total Building & Building Improvements Depreciation Expense			276,122		276,122		5,243,581	4
5	Home Office Allocated Depreciation Expense (from Page 8)			74,410		74,410			5
6	Less Adjustment for Rental of Facility Space			(40,083)		(40,083)			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)		$ 7,817,318	$ 310,449		$ 310,449	$	$ 5,243,581	34

**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: 07/01/2013 Ending: 06/30/2014

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	$ 3,280,665	$ 354,243	$ 354,243	$	7	$ 2,111,818	71
72	Current Year Purchases	306,241	16,400	16,400		7	16,400	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 3,586,906	$ 370,643	$ 370,643	$		$ 2,128,218	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	$ 42,097	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905				10	21,905	77
78	Nursing Facility	2005 Chevy Impala	2005	17,756	1,771	1,771		10	16,425	78
79	See Supplement Schedule			6,715	1,029	1,029			4,941	79
80	TOTALS			$ 91,480	$ 5,807	$ 5,807	$		$ 85,368	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)	$ 12,145,108	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 686,899	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 686,899	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)	$ 7,457,167	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	AL/IL Land, Building, Equipment	$ 59,520,385	$ 1,719,422	$ 9,647,637	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 59,520,385	$ 1,719,422	$ 9,647,637	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.

XI.D. Vehicle Costs - Supplemental Schedule

Line 79 - Vehicles

Use	Model, Make and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years
Nursing Facility	Trailer	2005	4,326	432	432		10
Nursing Facility	Wrap -Vehicle	2012	2,389	597	597		10
Total			**6,715**	**1,029**	**1,029**		

-

Accumulated Depreciation
3,711
1,230
3,912

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
    (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: 07/01/2013 Ending: 06/30/2014

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.

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	$	3,661	$ 294,303	$	3,661	$ 294,303	1
2	Licensed Speech and Language Development Therapist	10.3	hrs		468	41,412		468	41,412	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.3	hrs		5,288	505,649	1,498	5,288	507,147	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			$	9,417	$ 841,364	$ 1,498	9,417	$ 842,862	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: 07/01/2013 Ending: 06/30/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2014 (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	$ 2,636,636	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 266,733)	1,145,814		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	7,120,581		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	107,666		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,010,697	$	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	66,161,208		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,785,628		16
17	Accumulated Depreciation (book methods)	(17,104,804)		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):	6,621,346		22
23	Other(specify): See Supplemental Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 61,137,518	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 72,148,215	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,787,312	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,417,298		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	281,239		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,329,042		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,814,891	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	37,354,027		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	See Supplemental Schedule	32,069,905		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 69,423,932	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 74,238,823	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,090,608)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 72,148,215	$	48

***(See instructions.)**

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (186,726)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(926,578)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,113,304)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(977,304)	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)**	$ (977,304)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,090,608)	24 *

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	$ 17,239,687	1
2	Discounts and Allowances for all Levels	(1,107,550)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 16,132,137	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,289,543	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,289,543	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	68,276	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,983	15
16	Rental of Facility Space	96,075	16
17	Sale of Drugs	293,741	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	25,800	19
20	Radiology and X-Ray	22,463	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 509,338	23
	D. Non-Operating Revenue		
24	Contributions	665,427	24
25	Interest and Other Investment Income***	952,799	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,618,226	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	235,864	27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 235,864	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,785,108	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,647,670	31
32	Health Care	5,927,586	32
33	General Administration	3,661,123	33
	B. Capital Expense		
34	Ownership	4,598,182	34
	C. Ancillary Expense		
35	Special Cost Centers	524,526	35
36	Provider Participation Fee	212,315	36
	D. Other Expenses (specify):		
37	Marketing	1,191,010	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,762,412	40
41	**Income before Income Taxes (line 30 minus line 40)****	(977,304)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (977,304)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 455,545	44
45	Private Pay - Net Inpatient Revenue	13,788,140	45
46	Medicare - Net Inpatient Revenue	1,809,288	46
47	Other-(specify) Hospice	79,164	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 16,132,137	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.**

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	1,838	1,988	$ 99,368	$ 49.98	1
2	Assistant Director of Nursing	1,584	1,763	66,884	37.94	2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	112,980	112,847	1,338,266	11.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,212	4,439	64,137	14.45	9
10	Activity Assistants	15,477	16,936	228,591	13.50	10
11	Social Service Workers	5,463	5,976	163,407	27.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,815	4,166	65,847	15.81	14
15	Cook Helpers/Assistants	85,852	92,191	1,010,182	10.96	15
16	Dishwashers					16
17	Maintenance Workers	10,180	11,840	278,179	23.49	17
18	Housekeepers	31,382	32,856	373,807	11.38	18
19	Laundry	11,081	11,321	113,758	10.05	19
20	Administrator	1,823	1,973	121,877	61.77	20
21	Assistant Administrator	1,462	1,963	73,970	37.68	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,083	15,898	209,415	13.17	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	1,799	2,066	32,729	15.84	31
32	Other Health C: AL/IL	12,289	12,390	299,587	24.18	32
33	Other(specify) Marketing	4,947	5,967	165,897	27.80	33
34	TOTAL (lines 1 - 33)	321,267	336,580	$ 4,705,901 *	$ 13.98	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		24,000		36
37	Medical Records Consultant				37
38	Nurse Consultant	7,437	332,212	10.3	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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	7,437	$ 356,212		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	37,777	$ 1,143,073	10.3	50
51	Licensed Practical Nurses	34,149	943,230	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	71,926	$ 2,086,303		53

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Amanda Mauceri	Associate Executive Director	0	$ 73,970
Marti Jatis	Executive Director	0	121,877
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 195,847

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Hinshaw & Culbertson LLP	Legal	$ 121,456
Polsinelli Shughart PC	Legal	21,823
Paylocity	Payroll Service	15,638
Prove	Investigation	5,399
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 164,316

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 305,475
Unemployment Compensation Insurance	
FICA Taxes	336,089
Employee Health Insurance	346,088
Employee Meals	54,405
Illinois Municipal Retirement Fund (IMRF)*	
Disability Insurance	4,479
Life Insurance	4,607
Pension/401K Match	54,495
PTO Used / Not Paid	11,799
Tuition Reimbursement	4,666
Less: AL/IL Employee Benefits	(53,821)
Add: Home Office employee benefits	450,605
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,518,887

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,617
Health Care Worker Background Check	16,801
(Indicate # of checks performed 277)	
Patient Background Checks	
Dues & memberships	18,199
Subscriptions	2,406
Remove AL/IL costs	(175)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,848

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,183
Related meals	2,183
Seminar Expense	10,362
Remove AL/IL seminar & related costs	0
Add: Home Office allocation	21,179
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 37,907

* Attach copy of IMRF notifications

**See instructions.

Legal Expense Summary

POLSINELLI SHUGHART

9/20/2013	1005338	1,954	General business and IDPH matters
10/14/2013	1012644	1,949	IDPH matters, case status, general business
10/14/2013	1012645	2,708	
10/14/2013	1012646	127	
1/21/2014	1034363	2,968	
1/21/2014	1034364	6,479	
5/22/2014	1069172	932	
5/22/2014	1069173	4,066	
6/18/2014	1078787	641	
		21,823	

HINSHAW & CULBERTSON

8/19/2013	11273125	4,000	Labor relations items
9/12/2013	11279558	12,507	Collective bargaining and labor items
10/10/2013	11288562	11,750	Labor relations items
11/11/2013	11297610	11,623	Labor relations items
1/20/2014	11317797	31,198	Labor relations items and hearing
2/12/2014	11323036	15,279	Labor relations items
4/16/2014	11343230	10,744	Labor relations items
5/12/2014	11349499	12,673	Labor relations items and arbitration hearings
6/12/2014	11358499	11,680	Labor relations items and arbitration hearings
		121,456	

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2013 Ending: 06/30/2014

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	N/A		$		$	$	$	$	$	$	$	$	$
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: 07/01/2013 Ending: 06/30/2014

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 $12,324**

(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? **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? **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. $ **70,517** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **212,315**
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. $ **54,405** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **174,586**

(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? **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. $ **N/A**

(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 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.