FOR BHF USE

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

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: 05/26/1926

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501(C)(3)

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 07/01/2017 to 06/30/2018 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) Ema Araiza
(Title) Controller

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Deborah Freeland, Principal
(Firm Name & Address) CliftonLarsonAllen LLP, 9365 Counselors Row, Suite 200, 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: 07/01/2017 Ending: 06/30/2018

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	100	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	100	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	2,004	20,362	8,354	30,720	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,004	20,362	8,354	30,720	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.16%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 [ ] NO [X]

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 100 and days of care provided 8,354

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	1,202,828	108,855	608,142	1,919,825		1,919,825	(1,344,472)	575,353			1
2	Food Purchase		979,408		979,408		979,408	(842,370)	137,038			2
3	Housekeeping	515,588	58,502	18,330	592,420		592,420	(502,274)	90,146			3
4	Laundry	87,665	28,074	2,897	118,636		118,636	(100,584)	18,052			4
5	Heat and Other Utilities			490,676	490,676		490,676	(416,012)	74,664			5
6	Maintenance	209,344	20,309	953,930	1,183,583		1,183,583	(1,003,483)	180,100			6
7	Other (specify):*											7
8	TOTAL General Services	2,015,425	1,195,148	2,073,975	5,284,548		5,284,548	(4,209,195)	1,075,353			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	1,978,490	103,029	2,712,098	4,793,617		4,793,617	(663,274)	4,130,343			10
10a	Therapy		2,097	1,103,843	1,105,940		1,105,940		1,105,940			10a
11	Activities	436,205	8,920	239,589	684,714		684,714	(618,074)	66,640			11
12	Social Services	183,121	590	1,519	185,230		185,230	(156,544)	28,686			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,597,816	114,636	4,087,049	6,799,501		6,799,501	(1,437,892)	5,361,609			16
	C. General Administration											
17	Administrative					185,021	185,021		185,021			17
18	Directors Fees											18
19	Professional Services			53,078	53,078		53,078	13,236	66,314			19
20	Dues, Fees, Subscriptions & Promotions			81,837	81,837		81,837	(2,673)	79,164			20
21	Clerical & General Office Expenses	357,935	9,038	2,391,780	2,758,753	(185,021)	2,573,732	(698,690)	1,875,042			21
22	Employee Benefits & Payroll Taxes			1,194,380	1,194,380		1,194,380	332,675	1,527,055			22
23	Inservice Training & Education			9,909	9,909		9,909		9,909			23
24	Travel and Seminar			18,467	18,467		18,467	40,790	59,257			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			266,656	266,656		266,656	(202,010)	64,646			26
27	Other (specify):*											27
28	TOTAL General Administration	357,935	9,038	4,016,107	4,383,080		4,383,080	(516,672)	3,866,408			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,971,176	1,318,822	10,177,131	16,467,129		16,467,129	(6,163,759)	10,303,370			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 Num Smith Village # 0015032 **Report Period Beginning** 7/1/2017 **Ending:** 6/30/2018

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule		To Line	From Line
Reclassify administrator wages	$ 185,021	17	21

Facility Name & ID Number Smith Village #0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			2,173,498	2,173,498		2,173,498	(1,552,235)	621,263			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,009,643	1,009,643		1,009,643	(856,011)	153,632			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,195	28,195		28,195	(23,905)	4,290			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,211,336	3,211,336		3,211,336	(2,432,151)	779,185			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			512,584	512,584		512,584		512,584			39
40	Barber and Beauty Shops	48,874	11,241	85,739	145,854		145,854		145,854			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			192,841	192,841		192,841		192,841			42
43	Other (specify):* Marketing	198,490	1,461	800,453	1,000,404		1,000,404	(1,000,404)				43
44	**TOTAL Special Cost Centers**	247,364	12,702	1,591,617	1,851,683		1,851,683	(1,000,404)	851,279			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,218,540	1,331,524	14,980,084	21,530,148		21,530,148	(9,596,314)	11,933,834			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: 07/01/2017 Ending: 06/30/2018

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	(159,556)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(35,088)	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	(229,303)	21		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	(34,691)	11		17
18	Fines and Penalties	(675)	21		18
19	Entertainment				19
20	Contributions	(4,063)	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	(9,646)	21		24
25	Fund Raising, Advertising and Promotional	(930,765)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(8,348,137)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,751,924)		$	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)	155,610		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 155,610		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (9,596,314)		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

Smith Village

ID# 0015032

Report Period Beginning: 07/01/2017

Ending: 06/30/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL dietary costs	$ (1,344,472)	1	1
2	AL/IL food purchases	(685,889)	2	2
3	AL/IL housekeeping	(502,274)	3	3
4	AL/IL laundry	(100,584)	4	4
5	AL/IL heat & other utilities	(416,012)	5	5
6	AL/IL maintenance	(1,003,483)	6	6
7	AL/IL nursing costs	(663,274)	10	7
8	Life Enrichment (activities) income	(2,858)	11	8
9	AL/IL activities	(580,525)	11	9
10	AL/IL Employee Recruitment	(2,673)	20	10
11	AL/IL office & clerical	(60,583)	21	11
12	AL/IL nursing & activities emp benefits	(80,443)	22	12
13	AL/IL insurance	(226,080)	26	13
14	AL/IL & Apt depreciation	(1,564,658)	30	14
15	AL/IL bond interest	(856,011)	32	15
16	AL/IL Equipment/Vehicle Rent	(23,905)	35	16
17	Apartment Costs	(69,639)	43	17
18	Miscellaneous Revenue	(8,230)	21	18
19	AL/IL social service costs	(156,544)	12	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**	(8,348,137)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,344,472)	0	0	0	0	0	0	0	0	0	0	(1,344,472)	1
2	Food Purchase	(845,445)	3,075	0	0	0	0	0	0	0	0	0	(842,370)	2
3	Housekeeping	(502,274)	0	0	0	0	0	0	0	0	0	0	(502,274)	3
4	Laundry	(100,584)	0	0	0	0	0	0	0	0	0	0	(100,584)	4
5	Heat and Other Utilities	(416,012)	0	0	0	0	0	0	0	0	0	0	(416,012)	5
6	Maintenance	(1,003,483)	0	0	0	0	0	0	0	0	0	0	(1,003,483)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,212,270)	3,075	0	0	0	0	0	0	0	0	0	(4,209,195)	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	(663,274)	0	0	0	0	0	0	0	0	0	0	(663,274)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(618,074)	0	0	0	0	0	0	0	0	0	0	(618,074)	11
12	Social Services	(156,544)	0	0	0	0	0	0	0	0	0	0	(156,544)	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	(1,437,892)	0	0	0	0	0	0	0	0	0	0	(1,437,892)	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	13,236	0	0	0	0	0	0	0	0	0	13,236	19
20	Fees, Subscriptions & Promotions	(2,673)	0	0	0	0	0	0	0	0	0	0	(2,673)	20
21	Clerical & General Office Expenses	(312,500)	(386,190)	0	0	0	0	0	0	0	0	0	(698,690)	21
22	Employee Benefits & Payroll Taxes	(80,443)	413,118	0	0	0	0	0	0	0	0	0	332,675	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	40,790	0	0	0	0	0	0	0	0	0	40,790	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(226,080)	24,070	0	0	0	0	0	0	0	0	0	(202,010)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(621,696)	105,024	0	0	0	0	0	0	0	0	0	(516,672)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,271,858)	108,099	0	0	0	0	0	0	0	0	0	(6,163,759)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Village # 0015032 **Report Period Beginning:** 07/01/2017 **Ending:** 06/30/2018

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	(1,599,746)	47,511	0	0	0	0	0	0	0	0	0	(1,552,235)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(856,011)	0	0	0	0	0	0	0	0	0	0	(856,011)	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	(23,905)	0	0	0	0	0	0	0	0	0	0	(23,905)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,479,662)	47,511	0	0	0	0	0	0	0	0	0	(2,432,151)	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	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,000,404)	0	0	0	0	0	0	0	0	0	0	(1,000,404)	43
44	**TOTAL Special Cost Centers**	(1,000,404)	0	0	0	0	0	0	0	0	0	0	(1,000,404)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(9,751,924)	155,610	0	0	0	0	0	0	0	0	0	(9,596,314)	45

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	Chicago	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		$ 3,075	$ 3,075	1
2	V	19	Professional Serivces		Smith Senior Living		13,236	13,236	2
3	V	21	Clerical & General Office Exp		Smith Senior Living		1,278,481	1,278,481	3
4	V	22	PR Taxes & Employee Benefits		Smith Senior Living		413,118	413,118	4
5	V	24	Travel and Seminar		Smith Senior Living		40,790	40,790	5
6	V	26	Insurance		Smith Senior Living		24,070	24,070	6
7	V	30	Depreciation		Smith Senior Living		47,511	47,511	7
8	V								8
9	V								9
10	V	21	Management Fees	1,664,671				(1,664,671)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,664,671			$ 1,820,281	$ * 155,610	14

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	Thomas L. Hogan							1
2	Ann Haskins							2
3	Hugh J. Ahern							3
4	Alice E. Keane							4
5	Steven J. Murphy							5
6	Anne Z. Schaible							6
7	Michael P. Stanton							7
8	Kay E. Thurn							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: 07/01/2017 Ending: 06/30/2018

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 L. Hogan	Chair							$		1
2	Ann Haskins	Vice Chair									2
3	Hugh J. Ahern	Trustee									3
4	Alice E. Keane	Trustee									4
5	Steven J. Murphy	Trustee									5
6	Anne Z. Schaible	Trustee									6
7	Michael P. Stanton	Trustee									7
8	Kay E. Thurn	Ex-Officio									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: 07/01/2017 Ending: 6/30/2018

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
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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 Costs	38,713,414	2	$ 5,687	$	20,930,759	$ 3,075	1
2	19	Professional Serivces	Direct Costs	38,713,414	2	24,481		20,930,759	13,236	2
3	21	Clerical & General Office Exp	Direct Costs	38,713,414	2	2,364,671	1,621,073	20,930,759	1,278,481	3
4	22	PR Taxes & Employee Benefits	Direct Costs	38,713,414	2	764,101		20,930,759	413,118	4
5	24	Travel and Seminar	Direct Costs	38,713,414	2	75,445		20,930,759	40,790	5
6	26	Insurance	Direct Costs	38,713,414	2	44,519		20,930,759	24,070	6
7	30	Depreciation	Direct Costs	38,713,414	2	87,876		20,930,759	47,511	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					$ 3,366,780	$ 1,621,073		$ 1,820,281	25

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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 2016A		X	Refinance	$28,800.00	08/2016	$ 12,500,000	$ 11,859,420	11/15/46	0.0264	$ 387,146	1
2	IHFA Series 2016B		X	Refinance	$34,500.00	08/2016	15,000,000	14,232,024	11/15/46	0.0264	440,759	2
3	IHFA Series 2016C		X	Refinance	$11,400.00	08/2016	5,000,000	4,745,208	11/15/46	0.0264	141,117	3
4												4
5												5
	Working Capital											
6	Proven Business Systems		X	Copier Lease	$441.00	6/11/14	23,195	6,317	6/11/19	7.0000	621	6
7	Bond Amortization		X								40,000	7
8												8
9	TOTAL Facility Related				$75,141.00		$ 32,523,195	$ 30,842,969			$ 1,009,643	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule										(856,011)	13
14	TOTAL Non-Facility Related						$	$			$ (856,011)	14
15	TOTALS (line 9+line14)						$ 32,523,195	$ 30,842,969			$ 153,632	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: 07/01/2017 Ending: 06/30/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.**

2017 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

TELEPHONE (773) 474-7350 FAX #: (773) 474-7357

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 07/01/2017 Ending: 06/30/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,084 B. General Construction Type: Exterior Brick Frame Masonry 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: 07/01/2017 Ending: 06/30/2018

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	189,751		Various				13
14	Various			2008	58,315		Various				14
15	Various			2009	49,218		Various				15
16	Various			2010	2,209,240		Various				16
17	Various			2011	71,944		Various				17
18	Various			2012	131,397		Various				18
19	Various			2013	429		Various				19
20	Doors			2015	27,756		5				20
21	Elevator Reader			2015	1,637		5				21
22	New Parking Lot			2016	533,209		20				22
23	Elevator Project			2016	10,788		5				23
24	Smoking Area/Sidewalk repair			2016	6,600		5				24
25	Apt 4336 Upgrades, custom cabinets, hardwood floor, carpet			2016	36,678		10				25
26	Spa/Salon/Room 3303 updates, painting			2016	3,150		10				26
27	Library Repairs, move computer stations, custom desks			2016	2,070		10				27
28	Signage Updates, assisted living building named			2016	7,180		5				28
29	Laundry Room, added washing machines, removed walls			2016	5,946		5				29
30	Unit 3326 updates, new kitchen, carpet, cabinets, appliances			2016	39,956		5				30
31	LE Office Build, build in offices, custom countertops, flooring and paint			2016	27,450		5				31
32	ADA Doors, public restrooms and entrance rooms			2016	27,434		10				32
33	AL Office Project built in offices, custom countertops, flooring and			2016	22,987		10				33
34	Telephone System			2016	102,915		10				34
35	Wall Safes			2016	11,337		10				35
36	FOB Door Locks			2016	9,760		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: 07/01/2017 Ending: 06/30/2018

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	Totals from Page 12, Carried Forward		$ 8,625,857	$		$	$	$	37
38									38
39	Skilled Pipe Dining	2017	2,270		10				39
40	Rooms Enclose pipe chases	2017	2,900		5				40
41	Water Heater	2017	33,700		10				41
42	Water Heater	2017	6,000		10				42
43									43
44									44
45	Total Building & Building Improvements Depreciation Expense			28,631		28,631			45
46	Home Office Allocated Depreciation Expense (from Page 8)			47,511		47,511			46
47	Less Adjustment for Rental of Facility Space			(35,088)		(35,088)			47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 17,296,584	$ 41,054		$ 41,054	$	$	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: 07/01/2017 Ending: 06/30/2018

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	$ 3,830,594	$ 580,209	$ 580,209	$	Various	$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 3,830,594	$ 580,209	$ 580,209	$		$	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	$	$	$	15	$ 45,104	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905				10	21,905	77
78	Nursing Facility	2005 Chevy Impala	2005	17,756				10	17,756	78
79	See Supplement Schedule			6,715				Var	6,715	79
80	TOTALS			$ 91,480	$	$	$		$ 91,480	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)	$ 21,868,062	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 621,263	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 621,263	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)	$ 91,480	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	$ 60,021,185	$ 1,628,826	$ 16,179,589	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 60,021,185	$ 1,628,826	$ 16,179,589	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.

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 28,195 Description: $248 Admin Rental Equipment; $25,043 - tables, linens, and tableware; $2,904 Marketing Rental Equipmer
(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: 07/01/2017 Ending: 06/30/2018

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 ____

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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A - 3	hrs	$ 1,590		$ 449,460	$		$ 451,050	1
2	Licensed Speech and Language Development Therapist	10A - 3	hrs	7,606		110,483			118,089	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A - 3	hrs	6,518		543,900	2,097		552,515	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			$ 15,714		$ 1,103,843	$ 2,097		$ 1,121,654	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:** 07/01/2017 **Ending:** 06/30/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2018 (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	$ 2,535,104	$	1
2	Cash-Patient Deposits	127,835		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 382,833)	2,592,396		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	117,724		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,373,059	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,170,040		12
13	Land	2,200,239		13
14	Buildings, at Historical Cost	67,121,537		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,768,060		16
17	Accumulated Depreciation (book methods)	(24,785,481)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **See Attached**	1,844,538		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 59,318,933	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 64,691,992	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,480,072	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	331,524		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,526,959		36
37	Bonds Payable - Current Portion	941,400		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,279,955	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	29,489,896		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	32,210,425		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 61,700,321	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 65,980,276	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,288,284)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 64,691,992	$	48

***(See instructions.)**

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,257,261)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,257,261)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	968,977	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)**	$ 968,977	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)**	$ (1,288,284)	24 *

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	$ 19,004,135	1
2	Discounts and Allowances for all Levels	(991,229)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 18,012,906	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,031,874	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,031,874	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	106,586	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	187,416	16
17	Sale of Drugs	291,187	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,240	19
20	Radiology and X-Ray	22,727	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 640,156	23
	D. Non-Operating Revenue		
24	Contributions	230,663	24
25	Interest and Other Investment Income***	596,646	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 827,309	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	See Supplemental Schedule	986,880	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 986,880	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 22,499,125	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,284,548	31
32	Health Care	6,799,501	32
33	General Administration	4,383,080	33
	B. Capital Expense		
34	Ownership	3,211,336	34
	C. Ancillary Expense		
35	Special Cost Centers	1,658,842	35
36	Provider Participation Fee	192,841	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 21,530,148	40
41	**Income before Income Taxes (line 30 minus line 40)****	968,977	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 968,977	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 530,562	44
45	Private Pay - Net Inpatient Revenue	14,946,914	45
46	Medicare - Net Inpatient Revenue	2,459,364	46
47	Other-(specify) Hospice	76,066	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 18,012,906	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: 07/01/2017 Ending: 06/30/2018

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	1,842	2,072	$ 111,711	$ 53.91	1
2	Assistant Director of Nursing	1,725	2,215	79,437	35.86	2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	92,813	100,303	1,443,675	14.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,774	1,989	50,348	25.31	9
10	Activity Assistants	22,787	24,693	385,857	15.63	10
11	Social Service Workers	5,226	5,979	183,121	30.63	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	11,128	12,182	202,407	16.62	14
15	Cook Helpers/Assistants	76,506	81,142	1,000,421	12.33	15
16	Dishwashers					16
17	Maintenance Workers	8,093	9,056	209,344	23.12	17
18	Housekeepers	36,307	39,661	515,588	13.00	18
19	Laundry	6,610	7,142	87,665	12.27	19
20	Administrator	1,736	1,981	137,288	69.30	20
21	Assistant Administrator	1,725	1,950	46,197	23.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,493	9,216	113,953	12.36	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	1,844	2,122	34,838	16.42	31
32	Other Health C: Marketing	5,157	5,867	198,490	33.83	32
33	Other(specify) AL/IL/Salon	23,666	26,307	418,200	15.90	33
34	TOTAL (lines 1 - 33)	307,432	333,877	$ 5,218,540 *	$ 15.63	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		$ 585,235	1-3	35
36	Medical Director		30,000	9-3	36
37	Medical Records Consultant		2,800	10-3	37
38	Nurse Consultant	11,595	534,297	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		5,322	11-3	44
45	Social Service Consultant				45
46	Other(specify) Marketing Consultant		134,774	43-3	46
47	Agency Nursing	11,196	353,450	10-3	47
48					48
49	TOTAL (lines 35 - 48)	22,791	$ 1,645,878		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	19,770	$ 762,115	10-3	50
51	Licensed Practical Nurses	26,466	1,020,238	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	46,236	$ 1,782,353		53

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marti Jatis	Executive Director		$ 138,460
Kelley Flynn	Executive Admin Assistant		46,561
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 185,021

B. Administrative - Other

Description	Amount
Dues/Fees/Subscrip/Promos	$ 21,334
TOTAL (agree to Schedule V, line 17, col. 3)	$ 21,334
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Professional Services	Legal	$ 18,451
CliftonLarsonAllen LLP	Audit	14,100
Paylocity	Payroll	20,527
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 53,078

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 272,030
Unemployment Compensation Insurance	
FICA Taxes	413,558
Employee Health Insurance	408,930
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Disability	3,216
Life Insurance	2,283
Pension / 401K	74,288
PTO Used / Not Paid	15,422
Tuition	4,653
Less: Non-allowed AL/IL employee benefits	(80,443)
Add: Home Office employee benefits	413,118
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,527,055

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,526
Health Care Worker Background Check	13,216
(Indicate # of checks performed 152)	
Patient Background Checks 246	13,216
Dues & Memberships	13,104
Subscriptions	7,730
Association Dues	20,045
Less: Non-allowed AL/IL costs	(2,673)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 79,164

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,130
Seminar Expense	13,337
Add: Home Office Allocation	40,790
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 59,257

* Attach copy of IMRF notifications

**See instructions.

DETAILED TRIAL BALANCE FOR 2018

Account: **XXX-5410-0000-00-8020 - Admin - Legal Services**

			Invoice	Vendor	Amount	
Trx Date	**Jrnl No.**	**Orig. Audit Trail**	**Distribution Reference**	**Orig. Master Number**	**Debit**	**Credit**
31/12/2017	109660	IC	legal svcs 1204-122017	QUARLES & BRADY, LLC	364.00	
31/12/2017	109660	IC	legal svcs 1204-122017	QUARLES & BRADY, LLC	455.00	
31/01/2018	110397	PMTRX00004089	Svcs 12/2017	POLSINELLI SHUGHART	4,171.50	
31/01/2018	110442	IC	Svcs 01/2018	AKERMAN LLP	165.00	
28/02/2018	110728	PMTRX00004091	Svcs 0105-012518	POLSINELLI SHUGHART	649.50	
31/03/2018	111776	PMTRX00004112	Svcs 0201-020818	POLSINELLI SHUGHART	513.00	
30/04/2018	112288	PMTRX00004121	Svcs 03/2018	POLSINELLI SHUGHART	171.00	
30/04/2018	112790	PMTRX00004133	Svcs 0402-041718	POLSINELLI SHUGHART	199.50	
31/05/2018	113113	PMTRX00004142	Svcs 0315-042418	AKERMAN LLP	4,500.00	
28/06/2018	113347	PMTRX00004150	Svcs 05/2018	AKERMAN LLP	966.00	
30/06/2018	113680	PMTRX00004157	legal svcs 05/2018	POLSINELLI SHUGHART	342.00	
30/06/2018	113682	PMTRX00004157	Svcs 05/2018	OHAGAN MEYER	2,009.00	
					14,505.50	

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Leading Age - $20,933**

(3) Did the nursing home make political contributions or payments to a politica
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? **5-7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **42,774** 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 fo
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 Departmen
during this cost report period. $ **192,841**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **0** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **159,556**

(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 fo
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? **N/A**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **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