

Facility Name & ID Number Smith Village

0015032 Report Period Beginning: 7/1/07 Ending: 6/30/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,430	21,221	6,210	33,861	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,430	21,221	6,210	33,861	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.82%

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 103 and days of care provided 5,329

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/07 Ending: 6/30/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	865,997	198,480	369,694	1,434,171	255	1,434,426	(611,631)	822,795		1
2	Food Purchase		607,146		607,146		607,146	(258,930)	348,216		2
3	Housekeeping	281,942	62,483	14,387	358,812		358,812	(259,601)	99,211		3
4	Laundry	108,447	20,657	1,262	130,366		130,366	(94,320)	36,046		4
5	Heat and Other Utilities			416,175	416,175		416,175	(301,103)	115,072		5
6	Maintenance	318,941	16,568	245,861	581,370		581,370	(422,046)	159,324		6
7	Other (specify):* Unallowable expenses			8,795	8,795		8,795	(8,795)			7
8	TOTAL General Services	1,575,327	905,334	1,056,174	3,536,835	255	3,537,090	(1,956,426)	1,580,664		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	3,069,929	137,273	72,161	3,279,363		3,279,363	(1,152,939)	2,126,424		10
10a	Therapy			443,474	443,474		443,474		443,474		10a
11	Activities	418,209	18,394	83,206	519,809		519,809	(233,993)	285,816		11
12	Social Services	42,899		1,279	44,178		44,178		44,178		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Unallowable expenses			859	859		859	(859)			15
16	TOTAL Health Care and Programs	3,531,037	155,667	624,979	4,311,683		4,311,683	(1,387,791)	2,923,892		16
	C. General Administration										
17	Administrative	284,963		1,668,888	1,953,851	(149,403)	1,804,448	(1,713,078)	91,370		17
18	Directors Fees										18
19	Professional Services			104,002	104,002		104,002	7,907	111,909		19
20	Dues, Fees, Subscriptions & Promotions			65,042	65,042		65,042	(31,214)	33,828		20
21	Clerical & General Office Expenses	40,430	29,437	77,906	147,773	149,423	297,196	444,645	741,841		21
22	Employee Benefits & Payroll Taxes			1,418,188	1,418,188		1,418,188	(591,469)	826,719		22
23	Inservice Training & Education			4,097	4,097		4,097	1,412	5,509		23
24	Travel and Seminar			18,988	18,988	(275)	18,713	14,117	32,830		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			158,796	158,796		158,796	(40,495)	118,301		26
27	Other (specify):* Unallowable expenses			28,448	28,448		28,448	(28,448)			27
28	TOTAL General Administration	325,393	29,437	3,544,355	3,899,185	(255)	3,898,930	(1,936,623)	1,962,307		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,431,757	1,090,438	5,225,508	11,747,703		11,747,703	(5,280,840)	6,466,863		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.

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					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			1,170,985	1,170,985		1,170,985	(921,139)	249,846		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			1,698,247	1,698,247		1,698,247	(1,228,685)	469,562		32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):* Unallowable expenses			128,315	128,315		128,315	(128,315)			36
37	TOTAL Ownership			2,997,547	2,997,547		2,997,547	(2,278,139)	719,408		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		232,889	21,421	254,310		254,310		254,310		39
40	Barber and Beauty Shops			56,344	56,344		56,344	(50,115)	6,229		40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			56,548	56,548		56,548		56,548		42
43	Other (specify):* AL/IL, Marketing	255,252	12,916	(291,550)	(23,382)		(23,382)	23,382			43
44	TOTAL Special Cost Centers	255,252	245,805	(157,237)	343,820		343,820	(26,733)	317,087		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,687,009	1,336,243	8,065,818	15,089,070		15,089,070	(7,585,712)	7,503,358		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

STATE OF ILLINOIS
#0015032

Report Period Beginning: 7/1/2007

Ending: 6/30/2008
Part V Supplement

Part V - Reclassifications

		From Line	To Line
Reclassify clerical & other administrative wages	\$ 149,403	17	21
Reclassify employee orientation expense	20	24	21
Reclassify dining services	255	24	1

Smith Village

ID# 0015032

Report Period Beginning: 7/1/07

Ending: 6/30/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	AL/IL dietary costs	\$ (611,631)	1	1
2	AL/IL food purchases	(258,930)	2	2
3	AL/IL housekeeping	(259,601)	3	3
4	AL/IL laundry	(94,320)	4	4
5	AL/IL heat & other utilities	(301,103)	5	5
6	AL/IL maintenance	(416,896)	6	6
7	EVS late fee/finance charges	(511)	7	7
8	Cable tv	(8,284)	7	8
9	AL/IL nursing costs	(1,152,939)	10	9
10	AL/IL activities	(233,993)	11	10
11	Flowers	(883)	15	11
12	Activities late fees/interest (remove credit)	24	15	12
13	AL/IL administrative costs	(44,190)	17	13
14	Unallowable legal expenses	(85,070)	19	14
15	AL/IL professional services	(54,124)	19	15
16	Admissions advertising	(18,144)	20	16
17	AL/IL dues, fees, subs	(16,361)	20	17
18	AL/IL office & clerical	(358,771)	21	18
19	Marketing employee benefits	(54,024)	22	19
20	AL/IL nursing & activities employee benefits	(319,169)	22	20
21	AL/IL other employee benefits	(399,831)	22	21
22	AL/IL inservice training & education	(2,664)	23	22
23	AL/IL seminar & travel	(16,103)	24	23
24	Accessories for guest suite	(191)	24	24
25	AL/IL insurance	(57,215)	26	25
26	Investment advisory fee	(7,130)	27	26
27	Apt depreciation expense	(30,129)	30	27
28	AL/IL depreciation	(916,015)	30	28
29	AL/IL interest expense	(1,228,685)	32	29
30	Amort costs of acquiring continuing care contracts	(112,252)	36	30
31	Revenue offset - beauty shop	(50,115)	40	31
32	Apt building expenses & utilities	(30,656)	43	32
33	Interdepartment transfer (remove credit)	716,657	43	33
34	Marketing wages	(255,252)	43	34
35	Miscellaneous marketing expenses	(407,367)	43	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	(7,085,868)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Village# 0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(611,631)	0	0	0	0	0	0	0	0	0	0	(611,631)	1
2	Food Purchase	(258,930)	0	0	0	0	0	0	0	0	0	0	(258,930)	2
3	Housekeeping	(259,601)	0	0	0	0	0	0	0	0	0	0	(259,601)	3
4	Laundry	(94,320)	0	0	0	0	0	0	0	0	0	0	(94,320)	4
5	Heat and Other Utilities	(301,103)	0	0	0	0	0	0	0	0	0	0	(301,103)	5
6	Maintenance	(422,046)	0	0	0	0	0	0	0	0	0	0	(422,046)	6
7	Other (specify):*	(8,795)	0	0	0	0	0	0	0	0	0	0	(8,795)	7
8	TOTAL General Services	(1,956,426)	0	0	0	0	0	0	0	0	0	0	(1,956,426)	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	(1,152,939)	0	0	0	0	0	0	0	0	0	0	(1,152,939)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(233,993)	0	0	0	0	0	0	0	0	0	0	(233,993)	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):*	(859)	0	0	0	0	0	0	0	0	0	0	(859)	15
16	TOTAL Health Care and Programs	(1,387,791)	0	0	0	0	0	0	0	0	0	0	(1,387,791)	16
	C. General Administration													
17	Administrative	(44,190)	(1,668,888)	0	0	0	0	0	0	0	0	0	(1,713,078)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(139,194)	147,101	0	0	0	0	0	0	0	0	0	7,907	19
20	Fees, Subscriptions & Promotions	(34,505)	3,291	0	0	0	0	0	0	0	0	0	(31,214)	20
21	Clerical & General Office Expenses	(378,315)	822,960	0	0	0	0	0	0	0	0	0	444,645	21
22	Employee Benefits & Payroll Taxes	(773,024)	181,555	0	0	0	0	0	0	0	0	0	(591,469)	22
23	Inservice Training & Education	(2,664)	4,076	0	0	0	0	0	0	0	0	0	1,412	23
24	Travel and Seminar	(16,294)	30,411	0	0	0	0	0	0	0	0	0	14,117	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(57,215)	16,720	0	0	0	0	0	0	0	0	0	(40,495)	26
27	Other (specify):*	(28,448)	0	0	0	0	0	0	0	0	0	0	(28,448)	27
28	TOTAL General Administration	(1,473,849)	(462,774)	0	(1,936,623)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,818,066)	(462,774)	0	(5,280,840)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Village# 0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(946,144)	25,005	0	0	0	0	0	0	0	0	0	(921,139)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,228,685)	0	0	0	0	0	0	0	0	0	0	(1,228,685)	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	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(128,315)	0	0	0	0	0	0	0	0	0	0	(128,315)	36
37	TOTAL Ownership	(2,303,144)	25,005	0	(2,278,139)	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	(50,115)	0	0	0	0	0	0	0	0	0	0	(50,115)	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):*	23,382	0	0	0	0	0	0	0	0	0	0	23,382	43
44	TOTAL Special Cost Centers	(26,733)	0	0	0	0	0	0	0	0	0	0	(26,733)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(7,147,943)	(437,769)	0	(7,585,712)	45								

Facility Name & ID Number

Smith Village

0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Smith Crossing	Orland Park	Smith Senior Living	Chicago	Not-for-profit

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	19 Professional Services	\$	Smith Senior Living - Home Office		\$ 147,101	\$ 147,101	1
2	V	20 Fees, subscriptions & promo		Smith Senior Living - Home Office		3,291	3,291	2
3	V	21 Clerical & general office		Smith Senior Living - Home Office		822,960	822,960	3
4	V	22 Employee benefits		Smith Senior Living - Home Office		181,555	181,555	4
5	V	23 Inservice training & education		Smith Senior Living - Home Office		4,076	4,076	5
6	V	24 Travel & seminar		Smith Senior Living - Home Office		30,411	30,411	6
7	V	26 Insurance		Smith Senior Living - Home Office		16,720	16,720	7
8	V	30 Depreciation		Smith Senior Living - Home Office		25,005	25,005	8
9	V	17 Corporate Administration	1,668,888	Smith Senior Living - Home Office			(1,668,888)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,668,888			\$ 1,231,119	\$ * (437,769)	14

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

Facility Name & ID Number

Smith Village

0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Thomas E. Chomicz	Board Member	Trustee of the	None	26,096			Legal Services	\$ 7,800	19.3	1
2			board and Partner								2
3			at Quarles & Brady								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,800		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Smith Village

0015032

Report Period Beginning:

7/1/07

Ending: 6/30/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Direct Cost	25,088,654	2	\$ 244,586	\$ 15,089,070	\$ 147,101	1
2	20	Fees, subscriptions & promo	Direct Cost	25,088,654	2	5,472	15,089,070	3,291	2
3	21	Clerical & general office	Direct Cost	25,088,654	2	1,368,338	1,220,158	822,960	3
4	22	Employee benefits	Direct Cost	25,088,654	2	301,872	15,089,070	181,555	4
5	23	Inservice training & education	Direct Cost	25,088,654	2	6,778	15,089,070	4,076	5
6	24	Travel & seminar	Direct Cost	25,088,654	2	50,564	15,089,070	30,411	6
7	26	Insurance	Direct Cost	25,088,654	2	27,800	15,089,070	16,720	7
8	30	Depreciation	Direct Cost	25,088,654	2	41,576	15,089,070	25,005	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,046,986	\$ 1,220,158	\$ 1,231,119	25

Facility Name & ID Number Smith Village

0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	IHFA Series 2005A		X	Bond Refin & Construction	Varies	12/2005	\$ 34,305,000	\$ 34,305,000	11/2035	0.0604	\$ 1,048,024	1				
2	IHFA Series 2005B-1		X	Construction	Varies	12/2005	5,000,000	5,000,000	11/2035	0.0500	152,751	2				
3	IHFA Series 2005B-2		X	Construction	Varies	12/2005	2,500,000	2,500,000	11/2010	0.0500	76,375	3				
4	IHFA Series 2005C		X	Construction	Varies	12/2005	20,000,000	11,005,000	11/2010	Variable	336,205	4				
5	Net Amortized Debt Issuance		X								84,892	5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 61,805,000	\$ 52,810,000			\$ 1,698,247	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 61,805,000	\$ 52,810,000			\$ 1,698,247	15				

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Smith Village

0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 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 2008 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:	2003	_____	8
	2004	_____	9
	2005	_____	10
	2006	_____	11
	2007	_____	12

N/A

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2007	\$ _____	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.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Smith Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015032

CONTACT PERSON REGARDING THIS REPORT Douglas J. Grimes, CPA

TELEPHONE (574) 236-8669 FAX #: (574) 236-8692

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

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

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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Smith Village

0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

11365 S. Western Avenue - Apartments (costs adjusted out on page 5)

2315 W. 112th Place, Smith Village Assisted Living, 82 units, 65,000 square feet (costs adjusted out on page 5)

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 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Land</u>	<u>247,516</u>	<u>Pre 1994</u>	<u>\$ 649,404</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	247,516		\$ 649,404	3

Facility Name & ID Number Smith Village

0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	103		1992	\$ 4,868,578	\$ 139,102	35	\$ 139,102	\$	\$ 2,225,634	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10	Various		2003	43,521	6,228	10	6,228		29,586	10
11	Various		2004	10,236	2,047	5	2,047		8,515	11
12	Vinyl flooring - bathrooms		2005	4,960	496	10	496		1,984	12
13	Mini-blinds Johansen		2005	3,000	600	5	600		2,250	13
14	Mini-blinds Johansen		2005	4,017	803	5	803		2,946	14
15	Electrical wiring		2005	3,334	167	20	167		611	15
16	Painting lobby & auditorium		2005	1,950	390	5	390		1,398	16
17	Vinyl flooring		2005	26,260	2,626	10	2,626		9,410	17
18	Sewer line		2005	9,290	465	20	465		1,626	18
19	Surveillance camera		2005	1,864	373	5	373		1,305	19
20	Painting Johansen		2005	7,475	1,495	5	1,495		4,734	20
21	Painting Johansen		2005	4,300	860	5	860		2,723	21
22	Painting common areas		2005	3,302	660	5	660		2,036	22
23	Painting common areas		2006	1,936	387	7	387		1,033	23
24	Painting common areas		2006	720	144	7	144		372	24
25	Window treatments		2007	896	179	5	179		358	25
26	Initial Electronics - FOB Security		2007	16,522	1,652	10	1,652		2,891	26
27	Johansen - Upgrades - Building		2007	61,635	4,301	33	4,301		8,602	27
28	Johansen - Upgrades - Mechanical		2007	138,622	7,701	18	7,701		15,402	28
29	Johansen - Upgrades - Decorating		2007	19,355	1,935	10	1,935		3,871	29
30	Johansen - Upgrades - Carpeting		2007	14,530	2,906	5	2,906		5,812	30
31	Johnson Controls - Air compressor		2007	14,854	1,485	10	1,485		2,104	31
32	Viking Supply Net - Repair sprinkler heads		2007	3,696	370	10	370		400	32
33										33
34	Add Allocated Home Office Depreciation						25,005	25,005		34
35										35
36										36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Thyssenkrupp Elevator - wandering system	2007	\$ 3,457	\$ 317	10	\$ 317	\$	\$ 317	37
38	Red Hawk - security	2007	4,526	264	10	264		264	38
39	Thyssenkrupp Elevator - recall	2008	11,554	481	10	481		481	39
40	Chatham Rug	2008	1,025	26	10	26		26	40
41	Chatham Rug	2008	917	31	5	31		31	41
42	City Service Electrical, Inc.	2008	5,100	85	10	85		85	42
43	Thyssenkrupp Elevator	2008	8,286	138	10	138		138	43
44	Edwards Services Div	2008	2,817	47	10	47		47	44
45	Edwards Services Div	2008	2,909	48	10	48		48	45
46	Thyssenkrupp Smoke Detector	2008	2,142	36	10	36		36	46
47	Edwards Services Div	2008	1,786	15	10	15		15	47
48	Thyssenkrupp Smoke Detector	2008	14,821	124	10	124		124	48
49	Chatham Rug	2008	(1,025)	(1,025)	10	(1,025)		(1,025)	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)		\$ 5,323,168	\$ 177,959		\$ 202,964	\$ 25,005	\$ 2,336,190	70

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

Facility Name & ID Number Smith Village

0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 554,564	\$ 64,274	\$ 64,274	\$	7	\$ 265,525	71
72	Current Year Purchases	1,587,929	78,497	78,497		7	257,989	72
73	Fully Depreciated Assets	257,989				7	78,497	73
74	Remove AL/IL depreciation			(103,295)	(103,295)			74
75	TOTALS	\$ 2,400,482	\$ 142,771	\$ 39,476	\$ (103,295)		\$ 602,011	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Facility	2000 Ford Goshen Bus	2000	\$ 45,104	\$ 3,007	\$ 3,007	\$	15	\$ 24,056	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905	2,190	2,190		10	13,143	77
78	Nursing Facility	2005 Chevy Impala	2005	17,756	1,776	1,776		10	5,770	78
79	Nursing Facility	Trailer	2005	4,326	433	433		10	1,117	79
80	TOTALS			\$ 89,091	\$ 7,406	\$ 7,406	\$		\$ 44,086	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)	\$ 8,462,145	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 328,136	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 249,846	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (78,290)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,982,287	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land - Apt, Oakley St., Morrison	\$ 553,192	\$	\$	86
87	Building - Apt	487,975	12,199	140,293	87
88	Building Improvements - Apt	244,544	15,634	134,653	88
89	Furniture & Equip - Apt	84,047	2,295	33,417	89
90	Smith Village North Bldg	57,015,002	916,016	1,300,221	90
91	TOTALS	\$ 58,384,760	\$ 946,144	\$ 1,608,584	91

G. Construction-in-Progress

	Description	Cost	
92	Property Redevelopment	\$ 128,169	92
93			93
94			94
95		\$ 128,169	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 0 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	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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	\$	2,791	\$ 192,582	\$ 2,410	2,791	\$ 194,992	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		146	11,580	1,813	146	13,393	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		3,359	234,993	96	3,359	235,089	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$	6,296	\$ 439,155	\$ 4,319	6,296	\$ 443,474	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Smith Village**

0015032

Report Period Beginning: **7/1/07**

Ending:

6/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **6/30/08**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,236,341	\$	1
2	Cash-Patient Deposits	1,900,756		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (12,820))	576,074		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	143,863		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	13,809		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,870,843	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,122,722		12
13	Land	1,674,140		13
14	Buildings, at Historical Cost	62,599,144		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,573,621		16
17	Accumulated Depreciation (book methods)	(4,590,871)		17
18	Deferred Charges	2,842,124		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	8,222,593		21
22	Other Long-Term Assets (spec CIP)	128,169		22
23	Other(specify): <u>See Supplemental Schedule</u>	1,156,087		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 76,727,729	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 80,598,572	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,479,954	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	636,677		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	414,338		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	353,930		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	205,387		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,090,286	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	53,126,766		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>	15,659,948		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 68,786,714	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 71,877,000	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,721,572	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 80,598,572	\$	48

*(See instructions.)

Facility Name & ID Number: Smith Village

0015032 Report Period Beginning: 07/01/07

Ending: 06/30/08

Supplemental Schedule of Other Assets and Liabilities As of 6/30/07

Other Current Assets:	<u>Amount</u>	Other current Liabilities:	<u>Amount</u>
09A Other receivables	13,809	36A Resident credit balances	34,881
09B		36B Deferred revenue from non-refundable entrance fees	141,919
09C		36C Other current liabilities	28,587
09D		36D	
09E		36E	
09F		36F	
09G		36G	
	<u>13,809</u>		<u>205,387</u>
	<u>13,809</u>		<u>205,387</u>
Other Non-Current Assets:	<u>Amount</u>	Other Long-term Liabilities	<u>Amount</u>
23A Bond issuance costs, net of accumulated amortization	1,156,087	23A Due to Affiliate	1,282,194
23B		23B Obligation under interest rate swap agreement	304,994
23C		23C Refundable entrance fees	12,884,579
23D		23D Deferred revenue from non-refundable entrance fees	1,188,181
23E		23E	
23F		23F	
23G		23G	
	<u>1,156,087</u>		<u>15,659,948</u>
	<u>1,156,087</u>		<u>15,659,948</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,980,049	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,980,049	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(3,258,477)	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)	\$ (3,258,477)	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)	\$ 8,721,572	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 10,954,748	1
2	Discounts and Allowances for all Levels	(2,020,187)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,934,561	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,189,130	6
7	Oxygen	19,624	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,208,754	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	50,115	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	19,598	15
16	Rental of Facility Space	2,270	16
17	Sale of Drugs	190,193	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	20,218	19
20	Radiology and X-Ray	8,245	20
21	Other Medical Services	312,914	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 603,553	23
	D. Non-Operating Revenue		
24	Contributions	424,206	24
25	Interest and Other Investment Income***	400,551	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 824,757	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	258,968	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 258,968	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,830,593	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	3,536,835	31
32	Health Care	4,311,683	32
33	General Administration	3,899,185	33
	B. Capital Expense		
34	Ownership	2,997,547	34
	C. Ancillary Expense		
35	Special Cost Centers	287,272	35
36	Provider Participation Fee	56,548	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 15,089,070	40
41	Income before Income Taxes (line 30 minus line 40)**	(3,258,477)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (3,258,477)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

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

<u>Description</u>	<u>Amount</u>
Apartment Rents	\$ 132,110
Resident Meals	100,142
Underground Parking	9,458
Activities Entertainment	823
Resident Transport	2,880
Miscellaneous Resident Charges	4,782
Guest Room Income	3,000
Other Miscellaneous	5,773
	<u>\$ 258,968</u>

Line 25 Interest and Other Investment Income

Income reported on this line includes changes to the market value of investments and restricted funds. These amounts have not been offset against interest expense reported on Schedule V, line 32.

Facility Name & ID Number **Smith Village**

0015032

Report Period Beginning:

7/1/07

Ending:

6/30/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	4,284	5,241	\$ 206,682	\$ 39.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,844	21,566	450,421	20.89	3
4	Licensed Practical Nurses	20,557	30,717	574,024	18.69	4
5	CNAs & Orderlies	108,414	125,661	1,462,015	11.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,910	12,791	225,754	17.65	8
9	Activity Director	3,458	4,041	75,226	18.62	9
10	Activity Assistants	18,581	21,157	233,232	11.02	10
11	Social Service Workers	5,262	5,921	135,229	22.84	11
12	Dietician					12
13	Food Service Supervisor	3,989	4,606	60,064	13.04	13
14	Head Cook	1,705	2,053	39,685	19.33	14
15	Cook Helpers/Assistants	60,132	66,191	666,882	10.08	15
16	Dishwashers	8,427	9,021	75,354	8.35	16
17	Maintenance Workers	11,999	14,274	309,614	21.69	17
18	Housekeepers	29,046	32,719	323,547	9.89	18
19	Laundry	8,523	10,069	111,338	11.06	19
20	Administrator	1,766	2,021	114,448	56.63	20
21	Assistant Administrator	653	686	21,112	30.78	21
22	Other Administrative	11,266	12,253	129,879	10.60	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,680	1,982	31,781	16.03	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,550	1,845	28,250	15.31	31
32	Other Health C: MDS, Clinical Coo	3,861	5,374	139,312	25.92	32
33	Other(specify) <u>Marketing</u>	7,962	8,770	273,160	31.15	33
34	TOTAL (lines 1 - 33)	337,869	398,959	\$ 5,687,009 *	\$ 14.25	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	N/A	24,000	9.3	36
37	Medical Records Consultant	N/A	4,262	10.3	37
38	Nurse Consultant	N/A	10,874	10.3	38
39	Pharmacist Consultant	N/A	893	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	N/A	1,220	11.3	44
45	Social Service Consultant	N/A	171	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 41,420		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	64	\$ 4,062	10.3	50
51	Licensed Practical Nurses	32	861	10.3	51
52	Certified Nurse Assistants/Aides	28	860	10.3	52
53	TOTAL (lines 50 - 52)	123	\$ 5,783		53

Facility Name & ID Number Smith Village

0015032

Report Period Beginning:

7/1/2007 Ending:

6/30/2007

Page 21, C. Profession Fee Services - Detail of legal invoices

<u>Invoice No</u>	<u>Date</u>	<u>GL Acct.</u>	<u>Payee/Vendor</u>	<u>Amount</u>	<u>Comments</u>	<u>Amt to Adj. out</u>
1345950	07/17/07	52-41-810	Quarles & Brady LLP	\$ 85	General facility matters	\$ -
1345949	07/17/07	52-41-810	Quarles & Brady LLP	902	General facility matters	-
1345951	07/17/07	52-41-810	Quarles & Brady LLP	408	General facility matters	-
1364833	10/08/08	52-41-810	Quarles & Brady LLP	85	General facility matters	-
1378182	12/11/07	52-41-810	Quarles & Brady LLP	1,485	General facility matters	-
1384534	01/09/08	52-41-810	Quarles & Brady LLP	290	Investments, registration lobbying activities	(290)
1393719	02/19/08	52-41-810	Quarles & Brady LLP	1,619	Assisted/Independent living contracts	(1,619)
1404790	04/08/08	52-41-810	Quarles & Brady LLP	1,394	Apartments, bond redemption issues	(1,394)
1407373	07/17/08	52-41-810	Quarles & Brady LLP	364	Bond redumption issues	(364)
1413861	05/13/08	52-41-810	Quarles & Brady LLP	228	General facility matters	-
1413857	05/13/08	52-41-810	Quarles & Brady LLP	941	Assisted/Independent living matter	(941)
Stmt 1	09/05/07	52-41-810	Foote, Meyers, Mielke, & Flowers, LLC	83	General facility matters	-
8155251	07/01/07	52-41-810	Ungaretti & Harris	259	General facility matters	-
8158108	10/31/07	52-41-810	Ungaretti & Harris	259	General facility matters	-
8158106	10/31/07	52-41-810	Ungaretti & Harris	59	Home Health Agency issue	(59)
1476360	05/19/08	52-41-810	Seyfarth Shaw LLP	2,917	Employee matters	-
1476359	05/19/08	52-41-810	Seyfarth Shaw LLP	6,997	Employee matters	-
	Various	52-41-810		80,200	Accrued legal fees - settlement	(80,200)
	01/17/08	52-49-810	Chicago Title Insurance Company	60	Ownership search	(60)
	03/28/08	52-49-810	Chicago Title Insurance Company	60	Ownership search	(60)
	01/17/08	52-49-810	First American Title Insurance Company	85	Tract search	(85)
Total Legal Expenses				\$ 98,777	Total Unallowable	\$ (85,070)

Facility Name & ID Number Smith Village# 0015032Report Period Beginning: 7/1/07Ending: 6/30/08**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. Life Services Network - \$8,518
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 - 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,273 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 56,548
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. \$ 53,295 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? 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? 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: Crowe Horwath LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees