

Facility Name & ID Number Smith Village

0015032 Report Period Beginning: 7/1/2008 Ending: 6/30/2009

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	<u>103</u>	Skilled (SNF)	<u>103</u>	<u>37,595</u>	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	<u>103</u>	TOTALS	<u>103</u>	<u>37,595</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	Private Pay	4 Other	Total	
8	SNF	<u>7,098</u>	<u>20,031</u>	<u>5,410</u>	<u>32,539</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,098</u>	<u>20,031</u>	<u>5,410</u>	<u>32,539</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.55%

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 05/25/1926

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 4,266

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30 Fiscal Year: 06/30

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/2008 Ending: 6/30/2009

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	1,047,547	177,583	443,492	1,668,622		1,668,622	(908,327)	760,295		1
2	Food Purchase		832,429		832,429		832,429	(453,139)	379,290		2
3	Housekeeping	311,272	58,037	31,985	401,294		401,294	(317,022)	84,272		3
4	Laundry	103,272	22,923		126,195		126,195	(66,883)	59,312		4
5	Heat and Other Utilities			463,507	463,507		463,507	(366,171)	97,336		5
6	Maintenance	295,962	11,786	307,450	615,198		615,198	(486,007)	129,191		6
7	Other (specify):* Unallowable Exps			11,210	11,210		11,210	(11,209)	1		7
8	TOTAL General Services	1,758,053	1,102,758	1,257,644	4,118,455		4,118,455	(2,608,758)	1,509,697		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,481,000	94,154	630,493	3,205,647		3,205,647	(517,133)	2,688,514		10
10a	Therapy			464,227	464,227		464,227		464,227		10a
11	Activities	263,920	13,494	140,429	417,843		417,843	(208,921)	208,922		11
12	Social Services	108,408	74	959	109,441		109,441		109,441		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Unallowable Exps			1,015	1,015		1,015	(527)	488		15
16	TOTAL Health Care and Programs	2,853,328	107,722	1,261,123	4,222,173		4,222,173	(726,581)	3,495,592		16
	C. General Administration										
17	Administrative	356,309		1,374,077	1,730,386	(173,004)	1,557,382	(1,411,299)	146,083		17
18	Directors Fees										18
19	Professional Services			33,520	33,520		33,520	106,993	140,513		19
20	Dues, Fees, Subscriptions & Promotions			65,500	65,500		65,500	(31,548)	33,952		20
21	Clerical & General Office Expenses	48,761	33,592	80,915	163,268	173,004	336,272	772,025	1,108,297		21
22	Employee Benefits & Payroll Taxes			1,376,097	1,376,097		1,376,097	(285,013)	1,091,084		22
23	Inservice Training & Education			4,894	4,894		4,894	(754)	4,140		23
24	Travel and Seminar			15,752	15,752		15,752	2,716	18,468		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			145,983	145,983		145,983	(98,256)	47,727		26
27	Other (specify):* Unallowable Exps			(41,193)	(41,193)		(41,193)	41,193			27
28	TOTAL General Administration	405,070	33,592	3,055,545	3,494,207		3,494,207	(903,943)	2,590,264		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,016,451	1,244,072	5,574,312	11,834,835		11,834,835	(4,239,282)	7,595,553		29

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

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

Facility Name & ID Number

Smith Village

#0015032

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			1,936,262	1,936,262		1,936,262	(1,615,804)	320,458			30
31	Amortization of Pre-Op. & Org.			370,353	370,353		370,353	(362,842)	7,511			31
32	Interest			2,788,758	2,788,758		2,788,758	(2,412,269)	376,489			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Unallowable			11,483	11,483		11,483	(11,483)				36
37	TOTAL Ownership			5,106,856	5,106,856		5,106,856	(4,402,398)	704,458			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		252,972	16,810	269,782		269,782		269,782			39
40	Barber and Beauty Shops			62,750	62,750		62,750	(62,750)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,393	56,393		56,393		56,393			42
43	Other (specify):* Apt / Marketing	207,017	4,675	41,362	253,054		253,054	(253,054)				43
44	TOTAL Special Cost Centers	207,017	257,647	177,315	641,979		641,979	(315,804)	326,175			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,223,468	1,501,719	10,858,483	17,583,670		17,583,670	(8,957,484)	8,626,186			45

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

Smith VillageID# 0015032Report Period Beginning: 7/1/2008Ending: 6/30/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IL/AL Dietary Costs	\$ (908,327)	1	1
2	IL/AL Food Purchases	(453,139)	2	2
3	IL/AL Housekeeping	(317,022)	3	3
4	IL/AL Laundry	(66,883)	4	4
5	IL/AL Heating & Other Utilities	(366,171)	5	5
6	IL/AL Maintenance	(486,007)	6	6
7	EVS Late Fees	(191)	7	7
8	IL/AL Nursing Costs	(517,133)	10	8
9	IL/AL Activities	(208,921)	11	9
10	IL/AL Flowers	(488)	15	10
11	Life Enrichment Late Fees	(39)	15	11
12	IL/AL Administrative Costs	(37,222)	17	12
13	Unallowable Legal	(16,549)	19	13
14	IL/AL Professional Fees	(2,901)	19	14
15	Admission Advertising	(22,436)	20	15
16	IL/AL Dues, Fees, Subs	(15,571)	20	16
17	IL/AL Office, Clerical	(195,124)	21	17
18	Marketing Employee Benefits	(20,851)	22	18
19	IL/AL Nursing & Activities Employee Benefits	(93,035)	22	19
20	AL/IL Other Employee Benefits	(361,631)	22	20
21	IL/AL Inservice Training & Education	(3,012)	23	21
22	IL/AL Seminar & Travel	(9,582)	24	22
23	IL/AL Insurance	(115,327)	26	23
24	Prior Year Adjustments	41,582	27	24
25	IL/AL Other	280	27	25
26	IL/AL Depreciation	(1,674,425)	30	26
27	IL/AL Amortization	(362,842)	31	27
28	IL/AL Interest / Investments	(2,412,269)	32	28
29	Revenue Offset - Beauty Shop	(62,750)	40	29
30	Marketing Wages	(207,017)	43	30
31	Other Marketing Costs	(11,629)	43	31
32	Apt. Building Expense & Utilities	(34,408)	43	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	(8,941,040)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Village# 0015032

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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	(908,327)	0	0	0	0	0	0	0	0	0	0	(908,327)	1
2	Food Purchase	(453,139)	0	0	0	0	0	0	0	0	0	0	(453,139)	2
3	Housekeeping	(317,022)	0	0	0	0	0	0	0	0	0	0	(317,022)	3
4	Laundry	(66,883)	0	0	0	0	0	0	0	0	0	0	(66,883)	4
5	Heat and Other Utilities	(366,171)	0	0	0	0	0	0	0	0	0	0	(366,171)	5
6	Maintenance	(486,007)	0	0	0	0	0	0	0	0	0	0	(486,007)	6
7	Other (specify):*	(11,209)	0	0	0	0	0	0	0	0	0	0	(11,209)	7
8	TOTAL General Services	(2,608,758)	0	0	0	0	0	0	0	0	0	0	(2,608,758)	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	(517,133)	0	0	0	0	0	0	0	0	0	0	(517,133)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(208,921)	0	0	0	0	0	0	0	0	0	0	(208,921)	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):*	(527)	0	0	0	0	0	0	0	0	0	0	(527)	15
16	TOTAL Health Care and Programs	(726,581)	0	0	0	0	0	0	0	0	0	0	(726,581)	16
	C. General Administration													
17	Administrative	(37,222)	(1,374,077)	0	0	0	0	0	0	0	0	0	(1,411,299)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(19,450)	126,443	0	0	0	0	0	0	0	0	0	106,993	19
20	Fees, Subscriptions & Promotions	(38,007)	6,459	0	0	0	0	0	0	0	0	0	(31,548)	20
21	Clerical & General Office Expenses	(195,124)	967,149	0	0	0	0	0	0	0	0	0	772,025	21
22	Employee Benefits & Payroll Taxes	(475,517)	190,504	0	0	0	0	0	0	0	0	0	(285,013)	22
23	Inservice Training & Education	(3,012)	2,258	0	0	0	0	0	0	0	0	0	(754)	23
24	Travel and Seminar	(9,582)	12,298	0	0	0	0	0	0	0	0	0	2,716	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(115,327)	17,071	0	0	0	0	0	0	0	0	0	(98,256)	26
27	Other (specify):*	41,193	0	0	0	0	0	0	0	0	0	0	41,193	27
28	TOTAL General Administration	(852,048)	(51,895)	0	(903,943)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,187,387)	(51,895)	0	(4,239,282)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Village# 0015032

Report Period Beginning:

7/1/2008 Ending:6/30/2009

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	(1,674,425)	58,621	0	0	0	0	0	0	0	0	0	(1,615,804)	30
31	Amortization of Pre-Op. & Org.	(362,842)	0	0	0	0	0	0	0	0	0	0	(362,842)	31
32	Interest	(2,412,269)	0	0	0	0	0	0	0	0	0	0	(2,412,269)	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):*	(11,483)	0	0	0	0	0	0	0	0	0	0	(11,483)	36
37	TOTAL Ownership	(4,461,019)	58,621	0	(4,402,398)	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	(62,750)	0	0	0	0	0	0	0	0	0	0	(62,750)	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):*	(253,054)	0	0	0	0	0	0	0	0	0	0	(253,054)	43
44	TOTAL Special Cost Centers	(315,804)	0	0	0	0	0	0	0	0	0	0	(315,804)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(8,964,210)	6,726	0	0	0	0	0	0	0	0	0	(8,957,484)	45

Facility Name & ID Number

Smith Village

0015032

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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, IL	Smith Senior Living	Chicago, IL	

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		\$ 126,443	\$ 126,443	1
2	V	20 Fees, subscriptions & Promo		Smith Senior Living - Home Office		6,459	6,459	2
3	V	21 Clerical & general office		Smith Senior Living - Home Office		967,149	967,149	3
4	V	22 Employee Benefits		Smith Senior Living - Home Office		190,504	190,504	4
5	V	23 Inservice training & education		Smith Senior Living - Home Office		2,258	2,258	5
6	V	24 Travel & Seminar		Smith Senior Living - Home Office		12,298	12,298	6
7	V	26 Insurance		Smith Senior Living - Home Office		17,071	17,071	7
8	V	30 Depreciation		Smith Senior Living - Home Office		58,621	58,621	8
9	V	17 Corporate Administration	1,374,077				(1,374,077)	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,374,077			\$ 1,380,803	\$ * 6,726	14

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

Facility Name & ID Number

Smith Village

#

0015032

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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	18,967			Legal Svcs	\$ 9,422	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	\$ 9,422		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: 7/1/2008 Ending: 5/30/2009

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	27,473,574	2	\$ 197,549	\$ 17,584,733	\$ 126,443	1	
2	20	Fees, subscriptions & promo	Direct Cost	27,473,574	2	10,092	17,584,733	6,459	2	
3	21	Clerical & General Office	Direct Cost	27,473,574	2	1,511,029	1,220,158	17,584,733	967,149	3
4	22	Employee Benefits	Direct Cost	27,473,574	2	297,634	17,584,733	190,504	4	
5	23	Inservice training & educ	Direct Cost	27,473,574	2	3,528	17,584,733	2,258	5	
6	24	Travel & Seminar	Direct Cost	27,473,574	2	19,214	17,584,733	12,298	6	
7	26	Insurance	Direct Cost	27,473,574	2	26,672	17,584,733	17,072	7	
8	30	Depreciation	Direct Cost	27,473,574	2	91,586	17,584,733	58,621	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					\$ 2,157,304	\$ 1,220,158	\$ 1,380,804	25	

Facility Name & ID Number

Smith Village

0015032

Report Period Beginning:

7/1/2008

Ending:

6/30/2009

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
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	\$ 2,071,036	1								
2	IHFA Series 2005B-1	X	Construction	Varies	12/2005	5,000,000	5,000,000	11/2035	0.0500	250,000	2								
3	IHFA Series 2005B-2	X	Construction	Varies	12/2005	2,500,000	2,500,000	11/2010	0.0500	125,000	3								
4	IHFA Series 2005C	X	Construction	Varies	12/2005	20,000,000	4,970,000	11/2010	Variable	464,899	4								
5	Net Amortized Debt Issuance	X								72,989	5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related					\$ 61,805,000	\$ 46,775,000			\$ 2,983,924	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	\$ 46,775,000			\$ 2,983,924	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:

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Ending:

6/30/2009

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, Chicago, IL - 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:

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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	\$	\$ 2,364,737	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10	Various		2003	43,522	3,284	Various	3,284		32,869	10
11	Various		2004	10,236	1,721	Various	1,721		10,236	11
12	Various		2005	69,752	8,935	Various	8,935		39,957	12
13	Painting - Common Areas		2006	1,936	387	5	387		1,420	13
14	Painting - Common Areas		2006	720	144	5	144		516	14
15	Window Treatments		2007	896	179	5	179		537	15
16	Initial Electronics - FOB Security		2007	16,522	1,652	10	1,652		4,543	16
17	Johansen - Upgrades - Building		2007	61,635	4,301	14.33	4,301		12,903	17
18	Johansen - Upgrades - Mechanical		2007	138,622	7,701	18	7,701		23,104	18
19	Johansen - Upgrades - Decorating		2007	19,355	1,935	10	1,935		5,806	19
20	Johansen - Upgrades - Carpeting		2007	14,530	2,906	5	2,906		8,718	20
21	Johnson Controls - Air Compressor		2007	14,854	1,485	10	1,485		3,590	21
22	Viking Supply Net - Repair sprinkler heads		2007	3,697	370	10	370		770	22
23	Thyssnekrupp Elevator - Wondering System		2008	3,457	346	10	346		663	23
24	RED HAWK - Security		2008	4,526	453	10	453		717	24
25	THYSSENKRUPP Elevator-Recall		2008	11,554	1,155	10	1,155		1,637	25
26	Chatham Rug		2008	1,025	102	10	102		128	26
27	Chatham Rug		2008	917	183	5	183		214	27
28	City Service Electricial, Inc.		2008	5,100	510	10	510		595	28
29	THYSSENKRUPP Elevator		2008	8,286	829	10	829		967	29
30	Edwards Services Div		2008	2,817	282	10	282		329	30
31	Edwards Services Div		2008	2,909	291	10	291		339	31
32	THYSSENKRUPP Smoke Detector		2008	2,142	214	10	214		250	32
33	Edwards Services Div		2008	1,786	179	10	179		194	33
34	THYSSENKRUPP Smoke Detector		2008	14,821	1,482	10	1,482		1,606	34
35	Chatham Rug		2008	(1,025)		10			(1,025)	35
36	The Geo Group		2009	2,340	107	20	107		2,233	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

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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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Chatham Rug	2009	\$ 583	\$ 53	10	\$ 53		\$ 53	37
38	RED HAWK - Security	2009	7,000	583	10	583		583	38
39	Wall Products Inc	2009	5,113	284	15	284		284	39
40	Chatham Rug	2009	611	102	5	102		102	40
41	RED HAWK - Security	2009	8,553	546	10	546		546	41
42	Chatham Rug	2009	568	66	5	66		66	42
43	Sharlen Electric Company	2009	4,438	444	5	444		444	43
44	RED HAWK - Security	2009	1,450	72	10	72		72	44
45	Creative Carpet	2009	760	63	5	63		63	45
46	Creative Carpet	2009	808	67	5	67		67	46
47	Creative Carpet	2009	537	45	5	45		45	47
48	Creative Carpet	2009	466	39	5	39		39	48
49	Creative Carpet	2009	478	40	5	40		40	49
50	Creative Carpet	2009	466	39	5	39		39	50
51	Creative Carpet	2009	801	27	5	27		27	51
52	Creative Carpet	2009	807	27	5	27		27	52
53	Creative Carpet	2009	759	25	5	25		25	53
54	Creative Carpet	2009	808	27	5	27		27	54
55	Creative Carpet	2009	2,236	75	5	75		75	55
56	Creative Carpet	2009	759	13	5	13		13	56
57	Creative Carpet	2009	759	13	5	13		13	57
58	Creative Carpet	2009	807	13	5	13		13	58
59	Creative Carpet	2009	802		5				59
60	Creative Carpet	2009	759		5				60
61	C J Erickson Plumbing	2009	5,750	64	15	64		64	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,372,385	\$ 182,963		\$ 182,963	\$	\$ 2,521,279	70

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

Facility Name & ID Number Smith Village

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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	\$ 2,082,206	\$ 242,859	\$ 242,859	\$	7	\$ 529,806	71
72	Current Year Purchases	53,782	4,905	4,905		7	4,905	72
73	Fully Depreciated Assets	317,037	1,972	1,972		7	317,037	73
74								74
75	TOTALS	\$ 2,453,024	\$ 249,736	\$ 249,736	\$		\$ 851,747	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 Fort Goshen Bus	2000	\$ 45,104	\$ 3,007	\$ 3,007	\$	15	\$ 27,063	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905	2,190	2,190		10	15,333	77
78	Nursing Facility	2005 Chevy Impala	2005	17,756	1,776	1,776		10	7,546	78
79	Nursing Facility	Trailer	2005	4,326	433	433		10	1,550	79
80	TOTALS			\$ 89,091	\$ 7,406	\$ 7,406	\$		\$ 51,492	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)	\$ 8,563,905	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 440,104	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 440,104	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)	\$ 3,424,518	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 - Apartments	487,975	12,199	152,492	87
88	Building Improvements - Apts	244,554	15,913	150,566	88
89	F&E - Apartments	84,047	4,682	38,100	89
90	Smith Village North Building	58,081,304	1,508,942	2,809,163	90
91	TOTALS	\$ 59,451,072	\$ 1,541,737	\$ 3,150,321	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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: \$ _____ Description: _____
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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		hrs	\$	1,809	\$ 121,445	\$	1,809	\$ 121,445	1
2	Licensed Speech and Language Development Therapist		hrs		127	10,320		127	10,320	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,786	396,859		5,786	396,859	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			\$	7,722	\$ 528,624	\$	7,722	\$ 528,624	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# 0015032Report Period Beginning: 7/1/2008Ending: 6/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2009

(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	\$ 538,639	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	469,292		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	263,071		5
6	Prepaid Insurance	127,579		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	3,976		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,402,557	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	59,506		12
13	Land	1,674,140		13
14	Buildings, at Historical Cost	63,809,355		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,531,482		16
17	Accumulated Depreciation (book methods)	(6,527,133)		17
18	Deferred Charges	2,854,829		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	5,694,121		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Sch</u>	1,083,108		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 71,179,408	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 72,581,965	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,562,616	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	486,517		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	399,056		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	327,344		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	205,594		36
37	<u>Due to Affiliate</u>	145,532		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,126,659	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	47,074,330		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>	18,752,800		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 65,827,130	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 68,953,789	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,628,176	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 72,581,965	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,721,572	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,721,572	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(5,093,398)	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)	\$ (5,093,398)	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)	\$ 3,628,174	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Smith Village

0015032

Report Period Beginning: 7/1/2008

Ending:

6/30/2009

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	\$ 12,475,773	1
2	Discounts and Allowances for all Levels	(1,684,690)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,791,083	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	977,840	6
7	Oxygen	24,634	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,002,474	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	51,728	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	48,457	15
16	Rental of Facility Space	45,138	16
17	Sale of Drugs	184,925	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	18,779	19
20	Radiology and X-Ray	5,145	20
21	Other Medical Services	372,542	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 726,714	23
D. Non-Operating Revenue			
24	Contributions	662,213	24
25	Interest and Other Investment Income***	(1,017,411)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (355,198)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other (See Schedule)	325,200	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 325,200	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,490,273	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	4,118,456	31
32	Health Care	4,222,174	32
33	General Administration	3,494,207	33
B. Capital Expense			
34	Ownership	5,106,855	34
C. Ancillary Expense			
35	Special Cost Centers	585,586	35
36	Provider Participation Fee	56,393	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,583,671	40
41	Income before Income Taxes (line 30 minus line 40)**	(5,093,398)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (5,093,398)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 7/1/2008

Ending:

6/30/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,760	2,032	\$ 87,085	\$ 42.86	1
2	Assistant Director of Nursing	612	652	20,448	31.36	2
3	Registered Nurses	9,959	10,512	308,301	29.33	3
4	Licensed Practical Nurses	17,305	19,550	459,319	23.49	4
5	CNAs & Orderlies	111,105	126,716	1,480,303	11.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,376	2,760	48,628	17.62	9
10	Activity Assistants	17,766	20,241	237,220	11.72	10
11	Social Service Workers	2,844	3,127	72,115	23.06	11
12	Dietician					12
13	Food Service Supervisor	3,705	4,236	59,189	13.97	13
14	Head Cook	1,730	2,042	39,632	19.41	14
15	Cook Helpers/Assistants	83,221	89,711	884,275	9.86	15
16	Dishwashers					16
17	Maintenance Workers	25,578	28,664	428,453	14.95	17
18	Housekeepers	18,042	20,454	205,916	10.07	18
19	Laundry	9,711	11,452	115,159	10.06	19
20	Administrator	1,832	2,120	119,158	56.21	20
21	Assistant Administrator	3,597	3,959	102,622	25.92	21
22	Other Administrative	22,347	24,365	299,997	12.31	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	610	920	14,403	15.66	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,976	2,245	31,340	13.96	31
32	Other Health Care(specify)	1,551	2,076	68,200	32.85	32
33	Other(specify)	4,012	4,620	141,705	30.67	33
34	TOTAL (lines 1 - 33)	341,639	382,454	\$ 5,223,468 *	\$ 13.66	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	3,994	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,601	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	852	11.3	44
45	Social Service Consultant	N/A	959	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	\$	31,405		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	7,767	\$ 288,764	10.3	50
51	Licensed Practical Nurses	4,136	154,657	10.3	51
52	Certified Nurse Assistants/Aides			10.3	52
53	TOTAL (lines 50 - 52)	11,903	\$ 443,422		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kevin McGee	Executive Dir	0	\$ 119,158	Workers' Compensation Insurance	\$ 186,192	IDPH License Fee	\$ 2,234	
Amanda Senerchia	Asst Dir	0	64,147	Unemployment Compensation Insurance		Advertising: Employee Recruitment	8,424	
Other Admin Wages (Reclassified to Line 21)			173,004	FICA Taxes	385,526	Health Care Worker Background Check	8,587	
				Employee Health Insurance	433,999	(Indicate # of checks performed _____)		
				Employee Meals	45,675	Patient Background Checks	4,698	
				Illinois Municipal Retirement Fund (IMRF)*		AAHSA Dues	1,401	
				Dental Insurance	(1,062)	Admissions Advertising	38,665	
				Disability Insurance	6,518	Taxes & Fees	265	
				Life Insurance	3,756	Dues, Subs, Etx	1,423	
				Pension	304,194			
				Tuition Reimbursement	2,015	Less: Public Relations Expense	()	
				Employee Recognition	9,286	Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 356,309	TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,376,097	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 65,697	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Smith Senior Living - Corporate Administration (Removed through allocation of home office costs)			\$ 1,374,077				Out-of-State Travel	\$ 718
							In-State Travel	3,136
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,374,077				Seminar Expense	11,898
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
Chicago Title	Title Searches		\$ 420					
Crowe Horwath	Accounting		5,000					
Quarles & Brady	Legal		9,422					
Seyfarth & Shaw	Legal		14,170					
Thomas Scannell	Legal		754					
Foote, Meyers, Mielke	Legal		5					
Sabrina Goodwin	Legal Settlement		500					
Winfred Woods	Legal Settlement		3,250					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 33,520					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Smith Village# 0015032Report Period Beginning: 7/1/2008Ending: 6/30/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network - \$6,873
- (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. \$ 62,837 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. \$ 56,393
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. \$ 45,675 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
- (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.