

		FOR BHF USE					

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**2011  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
FINANCIAL AND STATISTICAL REPORT (COST REPORT)  
FOR LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2011)**

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

<p><b>I. IDPH License ID Number:</b> <u>0015032</u></p> <p><b>Facility Name:</b> <u>Smith Village</u></p> <p><b>Address:</b> <u>2320 West 113th Place</u> <u>Chicago</u> <u>60643</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 474-7300</u> <b>Fax #</b> <u>(773) 474-7302</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>5/25/1926</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code <u>501(C)(3)</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Raymond Marneris, CFO</u> <b>Telephone Number:</b> <u>(773) 474-7350</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(C)(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/01/2010</u> to <u>06/30/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Raymond Marneris</u> (Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) <u>Scott E. Martin, CPA</u> <u>Director</u> (Firm Name &amp; Address) <u>Crowe Horwath LLP</u> <u>330 E. Jefferson Blvd., P.O. Box 7, South Bend, IN 46624-000</u> (Telephone) <u>(574) 232-3992</u> Fax # <u>(574) 236-8692</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Raymond Marneris</u> (Title) <u>Chief Financial Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Scott E. Martin, CPA</u> <u>Director</u> (Firm Name & Address) <u>Crowe Horwath LLP</u> <u>330 E. Jefferson Blvd., P.O. Box 7, South Bend, IN 46624-000</u> (Telephone) <u>(574) 232-3992</u> Fax # <u>(574) 236-8692</u>
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Facility Name & ID Number Smith Village

# 0015032 Report Period Beginning: 7/01/2010 Ending: 06/30/2011

III. STATISTICAL DATA

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

	1	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	37,595	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	37,595	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	4 Private Pay	Other	Total	
8	SNF	4,091	20,773	8,329	33,193	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,091	20,773	8,329	33,193	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.29%

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 7,623

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: 6/30/2011 Fiscal Year: 6/30/2011

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/01/2010 Ending: 06/30/2011

**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
	<b>A. General Services</b>										
1	Dietary	1,049,935	159,077	628,566	1,837,578		1,837,578	(1,216,240)	621,338		1
2	Food Purchase		866,721		866,721		866,721	(616,168)	250,553		2
3	Housekeeping	325,579	57,201	16,947	399,727		399,727	(329,297)	70,430		3
4	Laundry	98,874	29,375	746	128,995		128,995	(105,518)	23,477		4
5	Heat and Other Utilities			522,920	522,920		522,920	(427,747)	95,173		5
6	Maintenance	279,308	6,736	346,907	632,951		632,951	(516,126)	116,825		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,753,696	1,119,110	1,516,086	4,388,892		4,388,892	(3,211,096)	1,177,796		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,471,343	86,105	918,623	3,476,071		3,476,071	(1,101,470)	2,374,601		10
10a	Therapy			861,409	861,409		861,409		861,409		10a
11	Activities	219,962	5,247	175,652	400,861		400,861	(100,532)	300,329		11
12	Social Services	148,001		936	148,937		148,937	(37,378)	111,559		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,839,306	91,352	1,980,620	4,911,278		4,911,278	(1,239,380)	3,671,898		16
	<b>C. General Administration</b>										
17	Administrative					186,007	186,007	(46,682)	139,325		17
18	Directors Fees										18
19	Professional Services			114,502	114,502		114,502	57,235	171,737		19
20	Dues, Fees, Subscriptions & Promotions			33,369	33,369		33,369	1,674	35,043		20
21	Clerical & General Office Expenses	370,176	27,662	1,668,012	2,065,850	(186,007)	1,879,843	(924,117)	955,726		21
22	Employee Benefits & Payroll Taxes			1,072,097	1,072,097		1,072,097	(41,335)	1,030,762		22
23	Inservice Training & Education			418	418		418	(1,395)	(977)		23
24	Travel and Seminar			23,310	23,310		23,310	(5,508)	17,802		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			125,188	125,188		125,188	(14,110)	111,078		26
27	Other (specify):* <b>Unallowable Exp</b>			37,231	37,231		37,231	(37,231)			27
28	<b>TOTAL General Administration</b>	370,176	27,662	3,074,127	3,471,965		3,471,965	(1,011,469)	2,460,496		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,963,178	1,238,124	6,570,833	12,772,135		12,772,135	(5,461,945)	7,310,190		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 &amp; ID Number

Smith Village

#0015032

Report Period Beginning:

7/01/2010

Ending:

06/30/2011

## 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			2,169,448	2,169,448		2,169,448	(1,319,497)	849,951			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,486,397	2,486,397		2,486,397	(2,033,866)	452,531			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,372	31,372		31,372	(25,662)	5,710			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			4,687,217	4,687,217		4,687,217	(3,379,025)	1,308,192			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			451,332	451,332		451,332		451,332			39
40	Barber and Beauty Shops			58,824	58,824		58,824	(49,021)	9,803			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,393	56,393		56,393		56,393			42
43	Other (specify):* Apts/Marketing	135,421	3,522	683,465	822,408		822,408	(822,408)				43
44	<b>TOTAL Special Cost Centers</b>	135,421	3,522	1,250,014	1,388,957		1,388,957	(871,429)	517,528			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,098,599	1,241,646	12,508,064	18,848,309		18,848,309	(9,712,399)	9,135,910			45

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

**Part V - Reclassifications**

		<b>To Line</b>	<b>From Line</b>
Reclassify executive director wages	\$ 121,079		
Reclassify associate executive director wages	<u>64,928</u>		
	<u><u>186,007</u></u>	17	21

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(127,077)	2		4
5	Telephone, TV & Radio in Resident Rooms	(26,636)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(249)	27		18
19	Entertainment				19
20	Contributions	(5,087)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,008)	27		24
25	Fund Raising, Advertising and Promotional	(488)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(9,373,020)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (9,555,565)</b>		<b>\$</b>	<b>30</b>

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(156,834)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (156,834)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (9,712,399)</b>		<b>37</b>

**\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

<b>BHF USE ONLY</b>							
48		49		50		51	52

Smith VillageID# 0015032Report Period Beginning: 7/01/2010Ending: 06/30/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	AL/IL dietary costs	\$ (1,216,240)	1	1
2	AL/IL food purchases	(490,446)	2	2
3	Guest Room Income	(12,755)	3	3
4	AL/IL housekeeping	(316,542)	3	4
5	AL/IL laundry	(105,518)	4	5
6	AL/IL heat & other utilities	(427,747)	5	6
7	Resident transport income	(2,019)	6	7
8	Maintenance income	(4,747)	6	8
9	AL/IL maintenance	(525,061)	6	9
10	AL/IL nursing costs	(1,101,470)	10	10
11	Life Enrichment (activities) income	(3,844)	11	11
12	AL/IL activities	(96,688)	11	12
13	AL/IL Administrative costs	(37,378)	12	13
14	AL/IL Administrative costs	(46,682)	17	14
15	Unallowable legal expenses	(2,916)	19	15
16	AL/IL professional services	(57,542)	19	16
17	Non-allowable lobbying expense	(2,703)	20	17
18	AL/IL membership fees	(2,319)	20	18
19	AL/IL Employee Recruitment	(710)	20	19
20	AL/IL office & clerical	(320,221)	21	20
21	Marketing employee benefits	(25,847)	22	21
22	AL/IL nursing & activities emp benefits	(190,123)	22	22
23	AL/IL inservice	328	23	23
24	Unsupport seminar & related costs	(14,386)	24	24
25	AL/IL travel & seminar	(5,964)	24	25
26	AL/IL insurance	(37,218)	26	26
27	Bank fees	(5,014)	27	27
28	Other taxes and fees	(3,385)	27	28
29	Apt depreciation	(24,175)	30	29
30	AL/IL & Apt depreciation	(1,362,731)	30	30
31	AL/IL bond interest	(2,033,866)	32	31
32	AL/IL Equipment/Vehicle Rent	(25,662)	35	32
33	Beauty shop income	(49,021)	40	33
34	Apt bldg expenses & utilities	(52,943)	43	34
35	Marketing wages	(135,421)	43	35
36	Misc marketing expenses	(634,044)	43	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	<b>Total</b>	(9,373,020)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Village# 0015032

Report Period Beginning:

7/01/2010

Ending:

06/30/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(1,216,240)	0	0	0	0	0	0	0	0	0	0	(1,216,240)	1
2	Food Purchase	(617,523)	1,355	0	0	0	0	0	0	0	0	0	(616,168)	2
3	Housekeeping	(329,297)	0	0	0	0	0	0	0	0	0	0	(329,297)	3
4	Laundry	(105,518)	0	0	0	0	0	0	0	0	0	0	(105,518)	4
5	Heat and Other Utilities	(427,747)	0	0	0	0	0	0	0	0	0	0	(427,747)	5
6	Maintenance	(531,827)	15,701	0	0	0	0	0	0	0	0	0	(516,126)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,228,152)</b>	<b>17,056</b>	<b>0</b>	<b>(3,211,096)</b>	<b>8</b>								
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,101,470)	0	0	0	0	0	0	0	0	0	0	(1,101,470)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(100,532)	0	0	0	0	0	0	0	0	0	0	(100,532)	11
12	Social Services	(37,378)	0	0	0	0	0	0	0	0	0	0	(37,378)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,239,380)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,239,380)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(46,682)	0	0	0	0	0	0	0	0	0	0	(46,682)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(60,458)	117,693	0	0	0	0	0	0	0	0	0	57,235	19
20	Fees, Subscriptions & Promotions	(5,732)	7,406	0	0	0	0	0	0	0	0	0	1,674	20
21	Clerical & General Office Expenses	(346,857)	(577,260)	0	0	0	0	0	0	0	0	0	(924,117)	21
22	Employee Benefits & Payroll Taxes	(215,970)	174,635	0	0	0	0	0	0	0	0	0	(41,335)	22
23	Inservice Training & Education	328	(1,723)	0	0	0	0	0	0	0	0	0	(1,395)	23
24	Travel and Seminar	(20,350)	14,842	0	0	0	0	0	0	0	0	0	(5,508)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(37,218)	23,108	0	0	0	0	0	0	0	0	0	(14,110)	26
27	Other (specify):*	(37,231)	0	0	0	0	0	0	0	0	0	0	(37,231)	27
28	<b>TOTAL General Administration</b>	<b>(770,170)</b>	<b>(241,299)</b>	<b>0</b>	<b>(1,011,469)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(5,237,702)</b>	<b>(224,243)</b>	<b>0</b>	<b>(5,461,945)</b>	<b>29</b>								

## STATE OF ILLINOIS

Facility Name & ID Number Smith Village# 0015032

Report Period Beginning:

7/01/2010 Ending:

Summary B

06/30/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(1,386,906)	67,409	0	0	0	0	0	0	0	0	0	(1,319,497)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,033,866)	0	0	0	0	0	0	0	0	0	0	(2,033,866)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(25,662)	0	0	0	0	0	0	0	0	0	0	(25,662)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,446,434)</b>	<b>67,409</b>	<b>0</b>	<b>(3,379,025)</b>	<b>37</b>								
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	(49,021)	0	0	0	0	0	0	0	0	0	0	(49,021)	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):*	(822,408)	0	0	0	0	0	0	0	0	0	0	(822,408)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(871,429)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(871,429)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(9,555,565)	(156,834)	0	0	0	0	0	0	0	0	0	(9,712,399)	45

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		<u>Smith Crossing</u>	<u>Orland Park</u>	<u>Smith Senior Living</u>	<u>Chicago</u>	<u>Home Office</u>

**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	<u>2 Food purchases</u>	\$	<u>Smith Senior Living</u>		\$ <u>1,355</u>	\$ <u>1,355</u>	1
2	V	<u>6 Maintenance</u>		<u>Smith Senior Living</u>		<u>15,701</u>	<u>15,701</u>	2
3	V	<u>19 Professional Services</u>		<u>Smith Senior Living</u>		<u>117,693</u>	<u>117,693</u>	3
4	V	<u>20 Fees, Subscriptions</u>		<u>Smith Senior Living</u>		<u>7,406</u>	<u>7,406</u>	4
5	V	<u>21 Clerical &amp; General Office Exp</u>		<u>Smith Senior Living</u>		<u>1,025,740</u>	<u>1,025,740</u>	5
6	V	<u>22 PR Taxes &amp; Employee Benefits</u>		<u>Smith Senior Living</u>		<u>174,635</u>	<u>174,635</u>	6
7	V	<u>23 Inservice Training &amp; Education</u>		<u>Smith Senior Living</u>		<u>(1,723)</u>	<u>(1,723)</u>	7
8	V	<u>24 Travel and Seminar</u>		<u>Smith Senior Living</u>		<u>14,842</u>	<u>14,842</u>	8
9	V	<u>26 Insurance</u>		<u>Smith Senior Living</u>		<u>23,108</u>	<u>23,108</u>	9
10	V	<u>30 Depreciation</u>		<u>Smith Senior Living</u>		<u>67,409</u>	<u>67,409</u>	10
11	V							11
12	V	<u>21 Corporate Administration</u>	<u>1,603,000</u>				<u>(1,603,000)</u>	12
13	V							13
14	Total		\$ <u>1,603,000</u>			\$ <u>1,446,166</u>	\$ * <u>(156,834)</u>	14

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

Facility Name &amp; ID Number

Smith Village

# 0015032

Report Period Beginning:

7/01/2010

Ending:

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## 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	14,291			Legal Services	\$ 2,403	19.3	1
2			Board and Partner		Smith Crossing						2
3			at Quarles & Brady								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,403		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:

7/01/2010

Ending: 6/30/2011

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

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

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

1	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	2	Food purchases	Direct Cost	28,891,294	2	\$ 2,077	\$ 18,848,309	\$ 1,355	1
2	6	Maintenance	Direct Cost	28,891,294	2	24,067	18,848,309	15,701	2
3	19	Professional Services	Direct Cost	28,891,294	2	180,404	18,848,309	117,693	3
4	20	Fees, Subscriptions	Direct Cost	28,891,294	2	11,352	18,848,309	7,406	4
5	21	Clerical & General Office Exp	Direct Cost	28,891,294	2	1,572,288	1,432,960	18,848,309	1,025,740
6	22	PR Taxes & Employee Benefits	Direct Cost	28,891,294	2	267,686	18,848,309	174,635	6
7	23	Inservice Training & Education	Direct Cost	28,891,294	2	(2,641)	18,848,309	(1,723)	7
8	24	Travel and Seminar	Direct Cost	28,891,294	2	22,750	18,848,309	14,842	8
9	26	Insurance	Direct Cost	28,891,294	2	35,421	18,848,309	23,108	9
10	30	Depreciation	Direct Cost	28,891,294	2	103,327	18,848,309	67,409	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					\$ 2,216,731	\$ 1,432,960	\$ 1,446,166	25

Facility Name & ID Number

Smith Village

# 0015032

Report Period Beginning:

7/01/2010

Ending:

06/30/2011

**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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	IHFA Series 2005A		X	Bond Refin & Construction	Varies	12/2005	\$ 34,305,000	\$ 34,305,000	11/2035	0.0604	\$ 2,094,158	1							
2	IHFA Series 2005B-1		X	Construction	Varies	12/2005	5,000,000	5,000,000	11/2035	0.0500	305,226	2							
3	IHFA Series 2005B-2		X	Construction	Varies	12/2005	2,500,000		11/2010	0.0500	63,589	3							
4	IHFA Series 2005C		X	Construction	Varies	12/2005	20,000,000		11/2010	Variable		4							
5												5							
<b>Working Capital</b>																			
6	Smith Senior Living	X		Working Capital		6/30/2010	2,004,303	2,004,303	6/30/2020	0.0238		6							
7	Smith Senior Living	X		Payoff IHFA Series 2005B-2		9/30/2010	2,500,000	1,523,424	9/30/2014	0.0250	23,424	7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 66,309,303	\$ 42,832,727			\$ 2,486,397	9							
<b>B. Non-Facility Related*</b>																			
10	Less AL/IL portion of interest expense										(2,033,866)	10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (2,033,866)	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 66,309,303	\$ 42,832,727			\$ 452,531	15							

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

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

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

**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 2010 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 2011 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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:	2006	_____	8
	2007	_____	9
	2008	_____	10
	2009	_____	11
	2010	_____	12

  

	<b>FOR BHF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.**

# 2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Smith Village COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0015032

CONTACT PERSON REGARDING THIS REPORT Raymond Marneris, CFO

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

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(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>
<b>TOTALS</b>			\$ <u><u></u></u>	\$ <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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

**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:

7/01/2010 Ending:

06/30/2011

**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).

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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	<b>TOTALS</b>	<b>247,516</b>		<b>\$ 649,404</b>	<b>3</b>

Facility Name &amp; ID Number Smith Village

# 0015032

Report Period Beginning:

7/01/2010

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**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$	35	\$	\$	\$
5										
6										
7										
8										
	<b>Improvement Type**</b>									
9										
10	Various		2003		43,522		Various			
11	Various		2004		10,236		Various			
12	Various		2005		69,752		Various			
13	Various		2006		2,656		Various			
14	Various		2007		270,111		Various			
15	Thyssenkrupp Elevator - Wandering System		2008		3,457		10			
16	Red Hawk - Security		2008		4,526		10			
17	Thyssenkrupp Elevator - Recall		2008		11,554		5			
18	Chatham Rug - carpet		2008		1,025		10			
19	Chatham Rug - carpet		2008		917		10			
20	City Service Electrical, Inc. - install conduit & wiring		2008		5,100		10			
21	Thyssenkrupp - elevator upgrade		2008		8,286		10			
22	Edwards Services Div - drawings & submittals		2008		2,817		10			
23	Edwards Services Div - fire project & parts		2008		2,909		10			
24	Thyssenkrupp - smoke detector		2008		2,142		10			
25	Edwards Services Div - inspection		2008		1,786		10			
26	Thyssenkrupp - smoke detector		2008		14,821		10			
27	Chatham Rug - carpet credit		2008		(1,025)		10			
28	The Geo Group - wall safes		2009		2,340		10			
29	Chatham Rug - carpet		2009		583		10			
30	Red Hawk - Security installation		2009		7,000		10			
31	Wall Products Inc. - wall safes		2009		5,113		15			
32	Chatham Rug - carpet		2009		611		5			
33	Red Hawk - installation of security cameras		2009		8,553		10			
34	Chatham Rug - carpet		2009		568		5			
35	Sharlen Electric Company - hand dryers and labor		2009		4,438		5			
36	Red Hawk - Security Relocation of Access Control Equipment		2009		1,450		10			

\*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 &amp; ID Number Smith Village

# 0015032

Report Period Beginning:

7/01/2010

Ending:

06/30/2011

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	Creative Carpet	2009	\$ 12,812	\$	5	\$	\$	\$	37
38	C J Erickson Plumbing	2009	5,750		15				38
39	Creative Carpet	2010	13,203		5				39
40	Johanson - Carpeting	2010	113,263		5				40
41	Johanson - Ceiling Tiles	2010	146,000		8				41
42	Johanson - Ceramic Tiling	2010	115,193		20				42
43	Johanson - Doors & Frames	2010	90,237		15				43
44	Johanson - Electrical	2010	258,533		20				44
45	Johanson - Elevator	2010	9,950		20				45
46	Johanson - Fire Security	2010	4,500		10				46
47	Johanson - HVAC	2010	13,557		15				47
48	Johanson - Plumbing	2010	129,583		25				48
49	Johanson - Resilient Floor	2010	107,896		20				49
50	Johanson - General Improvements Construction Costs	2010	1,001,585		15				50
51	Johanson - Smith U	2010	2,134		15				51
52	Johanson - Wellness Center	2010	54,465		15				52
53	City Service Electric - Emergency Power	2010	3,300		10				53
54	Carpeting	2010	13,239		5				54
55	Install Pipe and Wire Devices	2010	1,086		18				55
56	Tryslides	2010	5,578		10				56
57	Elevator Security System	2010	9,745		20				57
58	Johanson - Electrical	2010	9,574		14				58
59	Johanson - General Improvements Construction Costs	2010	32,529		15				59
60	Johanson - General Improvements Construction Costs	2010	70,962		15				60
61	Signage	2010	3,128		5				61
62	Signage	2011	7,356		7				62
63	Flooring	2011	11,832		10				63
64	Platform and handrails	2011	7,840		20				64
65	Carpeting	2011	44,916		5				65
66									66
67	Total Building & Building Improvements Depreciation Expense			728,863		728,863		3,633,629	67
68									68
69	Home Office Allocated Depreciation Expense (from Page 8)					67,409	67,409		69
70	TOTAL (lines 4 thru 69)		\$ 7,653,572	\$ 728,863		\$ 796,272	\$ 67,409	\$ 3,633,629	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:

7/01/2010

Ending:

06/30/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,682,580	\$ 291,047	\$ 42,923	\$ (248,124)	7	\$ 847,867	71
72	Current Year Purchases	66,466	3,350	3,350		7	3,350	72
73	Fully Depreciated Assets	317,037				7	317,037	73
74								74
75	TOTALS	\$ 3,066,083	\$ 294,397	\$ 46,273	\$ (248,124)		\$ 1,168,254	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Nursing Facility	2000 Ford Goshen Bus	2000	\$ 45,104	\$ 3,007	\$ 3,007		15	\$ 33,077	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905	2,191	2,191		10	19,714	77
78	Nursing Facility	2005 Chevy Impala	2005	17,756	1,776	1,776		10	11,097	78
79	Nursing Facility	Trailer	2005	4,326	432	432		10	2,415	79
80	TOTALS			\$ 89,091	\$ 7,406	\$ 7,406			\$ 66,303	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,458,150	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,030,666	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 849,951	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (180,715)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,868,186	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land - Apts, Oakley St, Morrison	\$ 553,192	\$	\$	86
87	Building - Apartments	459,415	25,244	166,745	87
88	Building Improvements - Apartments	287,069	18,615	171,913	88
89	Furnishings & Equipment - Apartments	84,048	5,560	44,435	89
90	Smith Village North Building	58,000,838	1,337,487	5,586,145	90
91	TOTALS	\$ 59,384,562	\$ 1,386,906	\$ 5,969,238	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	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: 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: \$ 31,372 Description: Copiers

(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. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

\* 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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (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	\$	5,529	\$ 415,918	\$	5,529	\$ 415,918	1
2	Licensed Speech and Language Development Therapist		hrs		397	31,525		397	31,525	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		5,593	413,392	574	5,593	413,966	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	<b>TOTAL</b>			\$	11,520	\$ 860,835	\$ 574	11,520	\$ 861,409	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: 7/01/2010Ending: 06/30/2011

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2011

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,290,308	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>(23,556)</u> )	1,073,632		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	202,998		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	73,359		7
8	Accounts Receivable (owners or related parties)	1,549,933		8
9	Other(specify): <u>Assets limited as to use</u>	853,975		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,044,205	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,674,140		13
14	Buildings, at Historical Cost	65,929,351		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,239,221		16
17	Accumulated Depreciation (book methods)	(10,824,207)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	6,785,964		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 66,804,469	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 71,848,674	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,536,800	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	416,899		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	297,941		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Supplemental Schedule</u>	936,625		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,188,265	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	39,569,456		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44	<u>See Supplemental Schedule</u>	27,805,792		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 67,375,248	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 70,563,513	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,285,161	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 71,848,674	\$	48

\*(See instructions.)

**XV. BALANCE SHEET - Supplemental Schedule**

**Line 23 - Other Assets**

<u>Description</u>	<u>Amount</u>
Assets limited as to use (Bond funds held by trustee)	\$ 962,438
Assets held in perpetual trust	65,840
Bond financing costs, net	3,623,289
Costs of acquiring initial continuing-care contracts, net	2,134,397
	<u>\$ 6,785,964</u>

**Line 36 - Other Current Liabilities**

<u>Description</u>	<u>Amount</u>
Resident credit balances	\$ 162,955
Deferred revenue from non-refundable entrance fees	179,968
Refundable reservation deposits	578,442
Other current liabilities	15,260
	<u>\$ 936,625</u>

**Line 44 - Other Long-term Liabilities**

<u>Description</u>	<u>Amount</u>
Due to affiliate - Smith Senior Living	\$ 3,059,748
Notes payable to affiliate - Smith Senior Living	3,527,727
Refundable entrance fees	19,785,071
Deferred revenue from non-refundable entrance fees	1,433,246
	<u>\$27,805,792</u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,001,316</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,001,316</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(716,155)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (716,155)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,285,161</b>	<b>24</b> *

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

Facility Name &amp; ID Number Smith Village

# 0015032

Report Period Beginning: 7/01/2010

Ending: 06/30/2011

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 15,646,876	1
2	Discounts and Allowances for all Levels	(611,500)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 15,035,376	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,453,240	6
7	Oxygen	20,212	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,473,452	8
<b>C. Other Operating Revenue</b>			
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	49,021	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	66,593	15
16	Rental of Facility Space	98,933	16
17	Sale of Drugs	338,589	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,410	19
20	Radiology and X-Ray	12,532	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 596,078	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	711,632	24
25	Interest and Other Investment Income***	179,775	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 891,407	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	135,841	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 135,841	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 18,132,154	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	4,388,892	31
32	Health Care	4,911,278	32
33	General Administration	3,471,965	33
<b>B. Capital Expense</b>			
34	Ownership	4,687,217	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	1,332,564	35
36	Provider Participation Fee	56,393	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 18,848,309	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(716,155)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (716,155)	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.

Facility Name & ID Number Smith Village# 0015032Report Period Beginning: 7/01/2010Ending: 06/30/2011

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

<u>Description</u>	<u>Amount</u>
Resident transport - private pay	\$ 2,019
Prior year adjustments	\$ (5,130)
Miscellaneous income	3,284
Life Enrichment (activities) income	3,844
Dining Services income	127,077
Maintenance charge-backs	4,747
	<u>\$ 135,841</u>

**Line 25 Interest and Other Investment Income**

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

Facility Name & ID Number Smith Village

# 0015032

Report Period Beginning: 7/01/2010

Ending:

06/30/2011

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	1,748	2,027	\$ 113,890	\$ 56.19	1
2	Assistant Director of Nursing	1,785	2,027	74,613	36.81	2
3	Registered Nurses	20,690	22,275	383,906	17.23	3
4	Licensed Practical Nurses	19,681	21,851	371,023	16.98	4
5	CNAs & Orderlies	106,102	122,823	1,359,127	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,555	4,102	59,978	14.62	8
9	Activity Director	1,285	1,392	35,679	25.63	9
10	Activity Assistants	15,035	17,642	184,283	10.45	10
11	Social Service Workers	5,270	5,916	148,001	25.02	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	983	1,216	22,501	18.50	14
15	Cook Helpers/Assistants	90,512	102,114	1,027,434	10.06	15
16	Dishwashers					16
17	Maintenance Workers	10,849	13,823	279,308	20.21	17
18	Housekeepers	25,317	31,000	325,579	10.50	18
19	Laundry	10,171	10,236	98,874	9.66	19
20	Administrator	1,768	2,022	121,079	59.88	20
21	Assistant Administrator	1,749	2,009	64,928	32.32	21
22	Other Administrative	11,934	13,551	184,169	13.59	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,844	2,117	33,130	15.65	31
32	Other Health C: See Supplement	4,554	5,088	75,676	14.87	32
33	Other(specify) <u>Marketing</u>	3,600	4,832	135,421	28.03	33
34	TOTAL (lines 1 - 33)	338,432	388,063	\$ 5,098,599 *	\$ 13.14	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	24,000	9.3	36	
37	Medical Records Consultant	2,328	10.3	37	
38	Nurse Consultant	256	15,498	10.3	38
39	Pharmacist Consultant	41	2,091	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	32	1,718	11.3	44
45	Social Service Consultant	12	728	12.3	45
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	341	\$ 46,363	49	

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8,031	\$ 316,274	10.3	50
51	Licensed Practical Nurses	11,424	337,847	10.3	51
52	Certified Nurse Assistants/Aides	20	380	10.3	52
53	TOTAL (lines 50 - 52)	19,475	\$ 654,501	53	

Facility Name &amp; ID Number

Smith Village

# 0015032

Report Period Beginning:

7/1/2010

Ending:

6/30/2011

## XVIII. A. STAFFING AND SALARY COSTS - Line 32 Other Health Care

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Ward Clerk	1,806	2,101	30,126	14.34
Assisted Living Coordinator	2,748	2,987	45,550	15.25
<b>Totals - Line 32</b>	<b>4,554</b>	<b>5,088</b>	<b>\$ 75,676</b>	<b>\$ 14.87</b>



Invoice No.	Date	GL Acct.	Payee/Vendor	Amount	Comments	Unallowable Expenses Adjustment
11207	12/16/2010	120-5460-8020	Probe	\$ 900	Confidential internal investigation, criminal histories	\$ -
1158	6/2/2011	120-5460-8020	The Mickus Group	22,344	Union consultant	-
11747	11/19/2010	120-5460-8020	Gilmore & Bell, P.C.	5,000	Remarketing of IFARR Bonds Series 2005 B-1	-
10-491	1/11/2011	120-5460-8020	Foote, Meyers, Mielke, & Flowers, LLC	180	West Group legal research	-
10-188	7/9/2010	120-5460-8020	Foote, Meyers, Mielke, & Flowers, LLC	30	West Group legal research	-
8478-017	7/9/2010	120-5460-8020	Foote, Meyers, Mielke, & Flowers, LLC	60	West Group legal research	-
1655821	4/7/2011	120-5460-8020	Quarles & Brady LLP	186	WJSmith Senior Living Trademark	(186)
1663945	5/10/2011	120-5460-8020	Quarles & Brady LLP	147	General facility matters	-
1606890	8/31/2010	120-5460-8020	Quarles & Brady LLP	992	Redevelopment project	(992)
1606894	8/31/2010	120-5460-8020	Quarles & Brady LLP	1,078	General facility matters	-
801798	6/9/2011	120-5460-8020	Polsinelli Shughart PC	198	General facility matters	-
794070	4/30/2011	120-5460-8020	Polsinelli Shughart PC	1,550	General facility matters	-
794070	6/24/2011	120-5460-8020	Polsinelli Shughart PC	1,378	AL resident issue	(1,378)
11042197	5/17/2011	120-5460-8020	Polsinelli Shughart PC	12,051	General facility matters / union election matters	-
11051240	6/20/2011	120-5460-8020	Polsinelli Shughart PC	9,098	General facility matters / union election matters	-
10960780	2/1/2011	120-5460-8020	Hinshaw & Culbertson LLP	(668)	Refund duplicate payment	-
10986195	10/20/2010	120-5460-8020	Hinshaw & Culbertson LLP	1,538	General facility matters	-
10999253	12/8/2010	120-5460-8020	Hinshaw & Culbertson LLP	600	General facility matters	-
10960780	7/20/2010	120-5460-8020	Hinshaw & Culbertson LLP	668	General facility matters	-
10953120	6/18/2010	120-5460-8020	Hinshaw & Culbertson LLP	2,554	General facility matters	-
Various	Various	120-5462-8020	Chicago Title Insurance Company	360	Title searches	(360)
				(580)	Journal entry to reclassify title searches to marketing	-
			Total Expenses	\$ 59,663		Total Adjustments \$ (2,916)
			A/C 120-5460-8020	\$ 59,303		
			A/C 120-5462-8020	360		
				\$ 59,663		

Payee	Topic	Attendee	Job Class	Location	Fee
Northern Illinois University	LSN Annual Meeting and Convention	Joy Shields	Activities	Chicago, IL	140
AAHSA	IL State Night at AAHSA	Kevin McGee	Administrative	Los Angeles, CA	40
Northern Illinois University	LSN Annual Meeting and Convention	Amanda Mauceri	Administrative	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Kevin McGee	Administrative	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Meagan Rohan	Administrative	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Theresa Rusch	Administrative	Chicago, IL	140
Leadership IQ	Webinar	All managers	Administrative	Online	150
South Suburban College	Activity Director Course	Joy Shields	Life Enrichment	South Holland, IL	399
Northern Illinois University	LSN Annual Meeting and Convention	Marge Everett	Marketing	Chicago, IL	140
AAHSA	IL State Night at AAHSA	Ed Torres	Nursing	Los Angeles, CA	40
HC Pro	MDS 3.0 Boot Camp	Marivic del Castillo	Nursing	Online	1,099
Northern Illinois University	LSN Annual Meeting and Convention	Marivic del Castillo	Nursing	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Shelly Genis	Nursing	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Sarah Jewett	Nursing	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Cindy Juarez	Nursing	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Diane Morgan	Nursing	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Cathy Nonan	Nursing	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Tabatha Paledin	Nursing	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Yahaira Ramirez	Nursing	Chicago, IL	140
Northern Illinois University	LSN Annual Meeting and Convention	Ed Torres	Nursing	Chicago, IL	140
Pathway Health Services	Restorative/Rehab Certification Program for Licensed Nurses	Tabatha Paledin	Nursing	Westmont, IL	749
Adler School of Professional Psychology	Continuing Education	Sarah Jewett	Nursing	Chicago, IL	100
AAHSA	AAHSA Conference	Ed Torres	Nursing	Los Angeles, CA	695
Courageous Aging	Courageous Aging	Sarah Jewett	Nursing	Aurora, IL	110
Skillpath Seminar	Managing Multiple Projects, Objectives and Deadlines	Tom Zarzycki	Social Services	Oak Brook, IL	149
Unsupported seminar expenses					14,386
				<b>Subtotal Seminar</b>	<b>20,015</b>
Related travel					2,690
Related meals					605
Less: Unsupported seminar expenses					(14,386)
				<b>Subtotal</b>	<b>\$ 8,924</b>
<b>Smith Senior Living Allocated Seminar Expenses:</b>					
AAHSA	AAHSA Annual Meeting	Kendra Bryant	Administration	Chicago, IL	195
HC Pro Opus Greeley	RUG IV	Mike Flynn	Administration	Chicago, IL	104
AAHSA	AAHSA	Mike Flynn	Administration	Chicago, IL	388
AAHSA	CEMO	Mike Flynn	Administration	Washington, DC	228
AAHSA	AAHSA 2009	Mike Flynn	Administration	Washington, DC	175
LSN E Commerce	CCRC Contracts	Mike Flynn	Administration	Chicago, IL	82
AAHSA	RUG Rules	Mike Flynn	Administration	Chicago, IL	65
Holiday INN	Exec Team Plan Mtg	Executive Team	Administration	Tinley Park, IL	475
LSN Conference 2010	LSN 2010	Kendra Bryant	Administration	Navy Pier, Chicago, IL	87
LSN Conference 2010	LSN 2010	Mike Flynn	Administration	Navy Pier, Chicago, IL	87
LSN Conference 2010	LSN 2010	Robert Boehn	Marketing	Navy Pier, Chicago, IL	87
LSN Conference 2010	LSN 2010	Maggie Porzio	Marketing	Navy Pier, Chicago, IL	87
BANK OF AMERICA	SkillPath	Karen Jellema	Human Resources	Chicago, IL	130
Lorman Education Svcs	Wellness Seminar	Kathy Quilty	Human Resources	Chicago, IL	117
COMMEG SYSTEMS, INC.	Labor maint and 73009 training 73009 training	Karen Jellema	Human Resources	Chicago, IL	221
AAHSA	AAHSA	Karen Jellema	Human Resources	Chicago, IL	195
Training Center	CD Training	Karen Jellema	Human Resources	Chicago, IL	130
Bus and Legal Reports	Plain English Compliance - CD Training	Karen Jellema	Human Resources	Chicago, IL	143
Rockhurst Univ.	Rockhurst Univ. Work Comp	Karen Jellema	Human Resources	Chicago, IL	153
LSN Conference 2010	LSN 2010	Karen Jellema	Human Resources	Navy Pier, Chicago, IL	87
LSN Conference 2010	LSN 2010	Kathy Quilty	Human Resources	Navy Pier, Chicago, IL	87
LSN	LSN Audio Conference	Deborah Hart	Accounting	Chicago, IL	65
AAHSA	AAHSA	Deborah Hart	Accounting	Chicago, IL	420
AICPA	AICPA Conference	Richard Sletten	Accounting	Orlando, Florida	793
Ziegler CFO Workshop	Ziegler CFO Workshop	Deborah Hart	Accounting	Denver, Colorado	192
LSN Conference 2010	LSN 2010	Ema Araiza	Accounting	Navy Pier, Chicago, IL	87
LSN Conference 2010	LSN 2010	Lorna Eich	Accounting	Navy Pier, Chicago, IL	87
LSN Conference 2010	LSN 2010	Deborah Hart	Accounting	Navy Pier, Chicago, IL	87
<b>LSN Conference 2010</b>	LSN 2010	Terry Simon	Accounting	Navy Pier, Chicago, IL	87
Craig Hanenburg	AAHSA Annual Meeting	Craig Hanenburg	IT	Chicago, IL	453
LSN Conference 2010	LSN 2010	Craig Hanenburg	IT	Chicago, IL	26
LSN Conference 2010	LSN 2010	Craig Hanenburg	IT	Navy Pier, Chicago, IL	87
LSN Conference 2010	LSN 2010	Jill Smazik	IT	Navy Pier, Chicago, IL	87
AAHSA	AAHSA	Jim Fitch	Projects	Chicago, IL	453
AAHSA	AAHSA 2009	Rick Maneris	Board	Washington, DC	260
AAHSA	AAHSA 2009	Robert Berghoff	Board	Washington, DC	260
Related travel expenses					7,034
Related meals					1,041
				<b>Subtotal</b>	<b>\$ 14,842</b>
Less: AL/IL portion of seminar & related expenses					(5,964)
				<b>Total Allowed Seminar &amp; Related Expenses</b>	<b>17,802</b>



Facility Name & ID Number Smith Village# 0015032Report Period Beginning: 7/01/2010Ending: 06/30/2011**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Life Services Network & AAHSA \$7,157
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 - 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 49,490 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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. \$ 49,380 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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.