



Facility Name & ID Number Smith Village

# 0015032 Report Period Beginning: 7/1/12 Ending: 6/30/13

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	4,063	24,185	5,684	33,932	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	4,063	24,185	5,684	33,932	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.26%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 5/25/1926

J. Was the facility purchased or leased after January 1, 1978?

YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?

YES  NO  If YES, enter number of beds certified 103 and days of care provided 5,858

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/13 Fiscal Year: 6/30/13

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

Facility Name &amp; ID Number

Smith Village

# 0015032

Report Period Beginning:

7/1/12

Ending:

6/30/13

**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	1,069,965	153,646	589,683	1,813,294		1,813,294	(1,217,332)	595,962		1
2	Food Purchase		948,347		948,347		948,347	(767,926)	180,421		2
3	Housekeeping	354,417	56,166	14,534	425,117		425,117	(360,429)	64,688		3
4	Laundry	107,827	27,285	653	135,765		135,765	(115,106)	20,659		4
5	Heat and Other Utilities			408,772	408,772		408,772	(346,571)	62,201		5
6	Maintenance	292,247	23,728	511,841	827,816		827,816	(707,630)	120,186		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,824,456	1,209,172	1,525,483	4,559,111		4,559,111	(3,514,994)	1,044,117		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	1,814,908	104,981	2,198,228	4,118,117		4,118,117	(503,378)	3,614,739		10
10a	Therapy			748,834	748,834		748,834		748,834		10a
11	Activities	259,580	12,736	189,341	461,657		461,657	(392,231)	69,426		11
12	Social Services	158,578		2,658	161,236		161,236		161,236		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,233,066	117,717	3,163,061	5,513,844		5,513,844	(895,609)	4,618,235		16
	<b>C. General Administration</b>										
17	Administrative					171,060	171,060		171,060		17
18	Directors Fees										18
19	Professional Services			87,335	87,335		87,335	119,358	206,693		19
20	Dues, Fees, Subscriptions & Promotions			44,530	44,530		44,530	(104)	44,426		20
21	Clerical & General Office Expenses	378,117	23,080	1,902,129	2,303,326	(171,060)	2,132,266	(690,472)	1,441,794		21
22	Employee Benefits & Payroll Taxes			989,790	989,790		989,790	285,586	1,275,376		22
23	Inservice Training & Education			490	490		490		490		23
24	Travel and Seminar			20,375	20,375		20,375	21,770	42,145		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			138,882	138,882		138,882	(89,837)	49,045		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	378,117	23,080	3,183,531	3,584,728		3,584,728	(353,699)	3,231,029		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,435,639	1,349,969	7,872,075	13,657,683		13,657,683	(4,764,302)	8,893,381		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.

STATE OF ILLINOIS

Part V Supplement

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/12 Ending: 6/30/13

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule

		To Line	From Line
Reclassify administrator wages	#####	17	21

Facility Name & ID Number Smith Village

#0015032

Report Period Beginning:

7/1/12

Ending:

6/30/13

## 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	
	<b>D. Ownership</b>											
30	Depreciation			2,212,881	2,212,881	2,212,881	(1,111,192)	1,101,689				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,381,125	2,381,125	2,381,125	(2,034,224)	346,901				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			27,104	27,104	27,104	(22,980)	4,124				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			4,621,110	4,621,110	4,621,110	(3,168,396)	1,452,714				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			363,586	363,586	363,586		363,586				39
40	Barber and Beauty Shops			61,365	61,365	61,365	(61,365)					40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,189	224,189	224,189		224,189				42
43	Other (specify):* <b>Marketing</b>	128,511	2,167	762,117	892,795	892,795	(892,795)					43
44	<b>TOTAL Special Cost Centers</b>	128,511	2,167	1,411,257	1,541,935	1,541,935	(954,160)	587,775				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,564,150	1,352,136	13,904,442	19,820,728	19,820,728	(8,886,858)	10,933,870				45

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

Facility Name & ID Number Smith Village

# 0015032

Report Period Beginning: 7/1/12

Ending: 6/30/13

**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	(132,006)	2		4
5	Telephone, TV & Radio in Resident Rooms	(26,406)	21		5
6	Rented Facility Space	(23,154)	30		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15,423)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(61,365)	40		16
17	Non-Care Related Fees	(5,779)	6		17
18	Fines and Penalties	(521)	21		18
19	Entertainment				19
20	Contributions	(706)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(168,615)	21		24
25	Fund Raising, Advertising and Promotional	(892,795)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(72,965)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(7,652,499)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (9,052,234)</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)	165,376	VII-B	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 165,376</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (8,886,858)</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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<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 Village

ID# 0015032

Report Period Beginning: 7/1/12

Ending: 6/30/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	AL/IL dietary costs	\$ (1,217,332)	1	1
2	AL/IL food purchases	(636,661)	2	2
3	AL/IL housekeeping	(360,429)	3	3
4	AL/IL laundry	(115,106)	4	4
5	AL/IL heat & other utilities	(346,571)	5	5
6	AL/IL maintenance	(701,851)	6	6
7	AL/IL nursing costs	(503,378)	10	7
8	Life Enrichment (activities) income	(822)	11	8
9	AL/IL activities	(391,409)	11	9
10	AL/IL Employee Recruitment	(104)	20	10
11	AL/IL office & clerical	(19,811)	21	11
12	AL/IL nursing & activities emp benefits	(45,238)	22	12
13	AL/IL insurance	(117,749)	26	13
14	AL/IL & Apt depreciation	(1,154,257)	30	14
15	AL/IL bond interest	(2,018,801)	32	15
16	AL/IL Equipment/Vehicle Rent	(22,980)	35	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(7,652,499)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Village# 0015032

Report Period Beginning:

7/1/12

Ending:

6/30/13

## 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	(1,217,332)	0	0	0	0	0	0	0	0	0	0	(1,217,332)	1
2	Food Purchase	(768,667)	741	0	0	0	0	0	0	0	0	0	(767,926)	2
3	Housekeeping	(360,429)	0	0	0	0	0	0	0	0	0	0	(360,429)	3
4	Laundry	(115,106)	0	0	0	0	0	0	0	0	0	0	(115,106)	4
5	Heat and Other Utilities	(346,571)	0	0	0	0	0	0	0	0	0	0	(346,571)	5
6	Maintenance	(707,630)	0	0	0	0	0	0	0	0	0	0	(707,630)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(3,515,735)</b>	<b>741</b>	<b>0</b>	<b>(3,514,994)</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	(503,378)	0	0	0	0	0	0	0	0	0	0	(503,378)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(392,231)	0	0	0	0	0	0	0	0	0	0	(392,231)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(895,609)</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>(895,609)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	119,358	0	0	0	0	0	0	0	0	0	119,358	19
20	Fees, Subscriptions & Promotions	(104)	0	0	0	0	0	0	0	0	0	0	(104)	20
21	Clerical & General Office Expenses	(289,024)	(401,448)	0	0	0	0	0	0	0	0	0	(690,472)	21
22	Employee Benefits & Payroll Taxes	(45,238)	330,824	0	0	0	0	0	0	0	0	0	285,586	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	21,770	0	0	0	0	0	0	0	0	0	21,770	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(117,749)	27,912	0	0	0	0	0	0	0	0	0	(89,837)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(452,115)</b>	<b>98,416</b>	<b>0</b>	<b>(353,699)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(4,863,459)</b>	<b>99,157</b>	<b>0</b>	<b>(4,764,302)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Village

# 0015032

Report Period Beginning:

7/1/12

Ending:

6/30/13

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	(1,177,411)	66,219	0	0	0	0	0	0	0	0	0	(1,111,192)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,034,224)	0	0	0	0	0	0	0	0	0	0	(2,034,224)	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	(22,980)	0	0	0	0	0	0	0	0	0	0	(22,980)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,234,615)</b>	<b>66,219</b>	<b>0</b>	<b>(3,168,396)</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	(61,365)	0	0	0	0	0	0	0	0	0	0	(61,365)	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):*	(892,795)	0	0	0	0	0	0	0	0	0	0	(892,795)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(954,160)</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>(954,160)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(9,052,234)	165,376	0	0	0	0	0	0	0	0	0	(8,886,858)	45

Facility Name & ID Number Smith Village

# 0015032

Report Period Beginning:

7/1/12

Ending:

6/30/13

**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>741</u>	\$ <u>741</u>	1
2	V	<u>19 Professional Services</u>		<u>Smith Senior Living</u>		<u>119,358</u>	<u>119,358</u>	2
3	V	<u>21 Clerical &amp; General Office Exp</u>		<u>Smith Senior Living</u>		<u>1,265,121</u>	<u>1,265,121</u>	3
4	V	<u>22 PR Taxes &amp; Employee Benefits</u>		<u>Smith Senior Living</u>		<u>330,824</u>	<u>330,824</u>	4
5	V	<u>24 Travel &amp; Seminar</u>		<u>Smith Senior Living</u>		<u>21,770</u>	<u>21,770</u>	5
6	V	<u>26 Insurance</u>		<u>Smith Senior Living</u>		<u>27,912</u>	<u>27,912</u>	6
7	V	<u>30 Depreciation</u>		<u>Smith Senior Living</u>		<u>66,219</u>	<u>66,219</u>	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V	<u>21 Corporate Administration</u>	<u>1,666,569</u>				<u>(1,666,569)</u>	12
13	V							13
14	<b>Total</b>		\$ <u>1,666,569</u>			\$ <u>1,831,945</u>	\$ * <u>165,376</u>	14

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

Facility Name & ID Number

Smith Village

# 0015032

Report Period Beginning:

7/1/12

Ending:

6/30/13

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Smith Village

# 0015032

Report Period Beginning:

7/1/12

Ending: 6/30/13

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	2	Food Purchases	Direct Cost	30,947,925	2	\$ 1,138	\$ 19,282,395	\$ 709	1
2	19	Professional Services	Direct Cost	30,947,925	2	182,957	19,282,395	113,993	2
3	21	Clerical & General Office Exp	Direct Cost	30,947,925	2	1,939,219	1,541,791	1,208,249	3
4	22	PR Taxes & Employee Benefits	Direct Cost	30,947,925	2	507,096	19,282,395	315,951	4
5	24	Travel & Seminar	Direct Cost	30,947,925	2	33,370	19,282,395	20,791	5
6	26	Insurance	Direct Cost	30,947,925	2	42,785	19,282,395	26,658	6
7	30	Depreciation	Direct Cost	30,947,925	2	101,503	19,282,395	63,242	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,808,068	\$ 1,541,791	\$ 1,749,593	25

Facility Name & ID Number

Smith Village

# 0015032

Report Period Beginning:

7/1/12

Ending:

6/30/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					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	\$ 32,900,000	11/2035	0.0604	\$ 1,992,486						
2	IHFA Series 2005B-1		X	Construction	Varies	12/2005	5,000,000	5,000,000	11/2035	0.0500	250,000						
3	IHFA Series 2005B-2		X	Construction	Varies	12/2005	2,500,000		11/2010	0.0500	131,011						
4	IHFA Series 2005C		X	Construction	Varies	12/2005	20,000,000		11/2010	Variable							
5																	
<b>Working Capital</b>																	
6	Smith Senior Living	X		Working Capital		6/30/2010	2,004,303		6/30/2020	0.0238							
7	Smith Senior Living	X		Payoff IHFA Series 2005B-2		9/30/2010	2,500,000		9/30/2014	0.0250	7,628						
8																	
9	<b>TOTAL Facility Related</b>						<b>\$ 66,309,303</b>	<b>\$ 37,900,000</b>			<b>\$ 2,381,125</b>						
<b>B. Non-Facility Related*</b>																	
10	Less AL/IL portion of interest expense																
11																	
12																	
13																	
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 66,309,303</b>	<b>\$ 37,900,000</b>			<b>\$ 2,381,125</b>						

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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>																	
1. Real Estate Tax accrual used on 2012 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 2013 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:	2008	_____	8	<table border="1"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2012 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
<b>FOR BHF USE ONLY</b>																			
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2009	_____	9																
	2010	_____	10																
	2011	_____	11																
	2012	_____	12																

**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.**

## 2012 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 2012 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 2012.

	(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.	N/A		\$	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		<b>TOTALS</b>	\$	\$

**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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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

Facility Name & ID Number Smith Village

# 0015032 Report Period Beginning:

7/1/12 Ending:

6/30/13

**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>	1
2					2
3	<b>TOTALS</b>	<b>247,516</b>		<b>\$ 649,404</b>	3

Facility Name &amp; ID Number Smith Village

# 0015032

Report Period Beginning:

7/1/12

Ending:

6/30/13

**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		54,202		Various			
12	Various		2005		69,752		Various			
13	Various		2006		2,656		Various			
14	Various		2007		258,065		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:

7/1/12

Ending:

6/30/13

**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	26,442		5				39
40	Johanson - Carpeting	2010	113,263		5				40
41	Johanson - Ceiling Tiles	2010	146,000		8				41
42	Johanson - Ceramic Tiling	2010	115,193		20				42
43	Johanson - Doors & Frames	2010	90,237		15				43
44	Johanson - Electrical	2010	258,533		20				44
45	Johanson - Elevator	2010	9,950		20				45
46	Johanson - Fire Security	2010	4,500		10				46
47	Johanson - HVAC	2010	13,557		15				47
48	Johanson - Plumbing	2010	129,583		25				48
49	Johanson - Resilient Floor	2010	107,896		20				49
50	Johanson - General Improvements Construction Costs	2010	1,001,585		15				50
51	Johanson - Smith U	2010	2,134		15				51
52	Johanson - Wellness Center	2010	54,465		15				52
53	City Service Electric - Emergency Power	2010	3,300		10				53
54	Install Pipe and Wire Devices	2010	1,086		18				54
55	Tryslides	2010	5,578		10				55
56	Elevator Security System	2010	9,745		20				56
57	Johanson - Electrical	2010	9,574		14				57
58	Johanson - General Improvements Construction Costs	2010	32,529		15				58
59	Johanson - General Improvements Construction Costs	2010	70,962		15				59
60	Signage	2010	3,128		5				60
61	Signage	2011	7,356		7				61
62	Flooring Replaced marketplace flooring	2011	11,832		10				62
63	Platform and handrails	2011	7,840		20				63
64	Carpeting 14 AL units, 19 IL units, Dining area	2011	44,916		5				64
65	IT OFC Remodel	2012	18,672		5				65
66	Carpeting 27 AL units, 29 IL units, Cafeteria	2012	74,813		5				66
67	Cabinets in AL kitchen	2012	21,692		10				67
68	Nurses Station Remodel	2013	429		15				68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 7,801,098	\$		\$	\$	\$	70

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

Facility Name & ID Number Smith Village

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,801,098	\$		\$	\$	\$	1
2	Cabinetry - Charting	2012	3,920		15				2
3	Johanson Courtyard	2012	12,300		15				3
4	Total Building & Building Improvements Depreciation Expense			718,019		718,019		5,064,486	4
5	Home Office Allocated Depreciation Expense (from Page 8)			66,219		66,219			5
6	Less Adjustment for Rental of Facility Space			(23,154)		(23,154)			6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,817,318	\$ 761,084		\$ 761,084	\$	\$ 5,064,486	34

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

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	\$ 2,991,615	\$ 323,069	\$ 323,069	\$	7	\$ 1,724,494	71
72	Current Year Purchases	403,089	9,533	9,533		7	9,533	72
73	Fully Depreciated Assets	317,037				7	317,037	73
74								74
75	TOTALS	\$ 3,711,741	\$ 332,602	\$ 332,602	\$		\$ 2,051,064	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	\$ 39,091	76
77	Nursing Facility	2002 Pick-up Truck	2002	21,905	2,191	2,191		10	24,096	77
78	Nursing Facility	2005 Chevy Impala	2005	17,756	1,776	1,776		10	14,649	78
79	See Supplement Schedule			6,715	1,029	1,029			3,912	79
80	TOTALS			\$ 91,480	\$ 8,003	\$ 8,003	\$		\$ 81,748	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,269,943	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,101,689	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,101,689	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 7,197,298	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	\$ 1,024,736	\$	\$	86
87	Building - Apartments	523,535	26,883	155,260	87
88	Building Improvements Apartments	308,641	27,028	228,322	88
89	Furnishings & Equip - Apartments	84,047		38,875	89
90	Smith Village North Building	57,465,175	1,127,374	7,606,471	90
91	TOTALS	\$ 59,406,134	\$ 1,181,285	\$ 8,028,928	91

G. Construction-in-Progress

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

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

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

XI.D. Vehicle Costs - Supplemental Schedule

Line 79 - Vehicles

	Use	Model, Make and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
	Nursing Facility	Trailer	2005	4,326	432	432		10	3,279
	Nursing Facility	Wrap -Vehicle	2012	2,389	597	597		10	633
<b>Total</b>				<b>6,715</b>	<b>1,029</b>	<b>1,029</b>			<b>3,912</b>

-

**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

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

13. \_\_\_\_\_ /2015                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016                      \$ \_\_\_\_\_

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: \$ N/A Description: N/A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/12 Ending: 6/30/13  
 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><u>CNA's have received training and certification prior to being hired with Smith Village.</u></p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10.3	hrs	\$	2,756	\$ 310,904	\$	2,756	\$ 310,904	1	
2	Licensed Speech and Language Development Therapist	10.3	hrs		498	44,471		498	44,471	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10.3	hrs		3,364	393,459		3,364	393,459	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>			\$	6,618	\$ 748,834	\$	6,618	\$ 748,834	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.

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 674,281	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>225,830</u> )	1,028,501		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	5,856,589		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	103,569		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 7,662,940	\$	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	66,114,669		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,887,268		16
17	Accumulated Depreciation (book methods)	(15,226,226)		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>	7,105,813		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 63,555,664	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 71,218,604	\$	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,879,607	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	393,114		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	288,731		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Supplemental Schedule</u>	1,280,123		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,841,575	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	38,177,306		41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44	<u>See Supplemental Schedule</u>	29,386,449		44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 67,563,755	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 71,405,330	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (186,726)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 71,218,604	\$	48

\*(See instructions.)

XV. BALANCE SHEET - Supplemental Schedule

Line 23 - Other Assets	
Description	Amount
Assets limited as to use	4,544,154
Assets held in perpetual trust	63,851
Bond financing costs	1,083,842
Cost of acquiring continuin care contracts	1,413,966
Due to/from related party	-
	<u>7,105,813</u>

Line 36 - Other Current Liabilities	
Description	Amount
Resident Credit Balances	367,350
Refundable reservation deposit	726,832
Deferred Revenue from non refundable entrance fee	184,150
Other Current Liabilities	1,791
	<u>1,280,123</u>

Line 44 - Other Long Term Liabilities	
Description	Amount
Notes Payable to affiliate - SSL	2,486,641
Refundable entrance fees	21,310,465
Deferred Revenue from non-refundable entrance fee	1,103,425
Due to/from Related Deferred Mgt Fees	4,485,918
	<u>29,386,449</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 784,441	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 784,441	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(971,167)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (971,167)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (186,726)	24 *

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

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 17,490,857	1
2	Discounts and Allowances for all Levels	(1,160,085)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 16,330,772</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,238,764	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 1,238,764</b>	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	70,106	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	26,406	15
16	Rental of Facility Space	77,694	16
17	Sale of Drugs	212,860	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,072	19
20	Radiology and X-Ray	19,298	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 428,436</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	634,745	24
25	Interest and Other Investment Income***	65,643	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 700,388</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	151,202	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 151,202</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 18,849,562</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	4,559,111	31
32	Health Care	5,513,844	32
33	General Administration	3,584,728	33
<b>B. Capital Expense</b>			
34	Ownership	4,621,110	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	424,951	35
36	Provider Participation Fee	224,189	36
<b>D. Other Expenses (specify):</b>			
37	<u>Marketing</u>	892,795	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 19,820,728</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(971,166)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (971,166)</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 530,813	44
45	Private Pay - Net Inpatient Revenue	12,874,666	45
46	Medicare - Net Inpatient Revenue	2,697,204	46
47	Other-(specify) <u>Hospice</u>	207,202	47
48	Other-(specify) <u>Other</u>	20,887	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 16,330,772</b>	49

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

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

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

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

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

<u>Description</u>	<u>Amount</u>
Miscellaneous income	12,595
Life Enrichment (activities) income	822
Dining Services income	132,006
Maintenance charge-backs	5,779
	<u>\$151,202</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:

7/1/12

Ending:

6/30/13

**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	3,972	4,061	\$ 202,697	\$ 49.91	1
2	Assistant Director of Nursing	1,819	1,827	20,974	11.48	2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	138,115	138,759	1,688,147	12.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,534	3,558	65,999	18.55	9
10	Activity Assistants	16,452	16,524	191,665	11.60	10
11	Social Service Workers	5,151	5,196	111,232	21.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	25,793	25,931	359,327	13.86	14
15	Cook Helpers/Assistants	52,438	52,582	536,392	10.20	15
16	Dishwashers					16
17	Maintenance Workers	14,534	14,626	203,365	13.90	17
18	Housekeepers	24,915	25,025	274,588	10.97	18
19	Laundry	10,338	10,383	108,066	10.41	19
20	Administrator	1,651	1,679	103,029	61.36	20
21	Assistant Administrator	1,972	2,003	72,640	36.27	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,169	11,213	144,231	12.86	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	2,020	2,034	32,676	16.06	31
32	Other Health C: Other	11,682	11,804	287,253	24.34	32
33	Other(specify) <u>Marketing</u>	5,926	5,996	161,870	27.00	33
34	TOTAL (lines 1 - 33)	331,481	333,201	\$ 4,564,151 *	\$ 13.70	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			36	
37	Medical Records Consultant			37	
38	Nurse Consultant	10,846	367,733	10.3	38
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant			44	
45	Social Service Consultant			45	
46	Other(specify)			46	
47				47	
48				48	
49	TOTAL (lines 35 - 48)	10,846	\$ 367,733	49	

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	29,292	\$ 836,534	10.3	50
51	Licensed Practical Nurses	24,675	643,432	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	53,967	\$ 1,479,966		53



**Legal Expense Summary**

POLSINELLI SHUGHART	9/27/2012	\$1,691.00
	4/30/2013	\$884.00
	4/30/2013	\$276.00
	6/24/2013	\$3,727.50
QUARLES & BRADY	7/31/2012	\$57.00
	8/28/2012	\$192.00
	3/31/2013	\$97.50
	4/30/2013	\$96.00
	5/31/2013 Smith Parking Project	\$860.95
HINSHAW & CULBERTSON	8/28/2012	\$682.50
	9/30/2012	\$1,895.64
	#####	\$2,137.50
	#####	\$3,450.00
	#####	\$652.50
	#####	\$8,168.70
	#####	\$1,755.00
	##### Employee Leave Matte	\$10,722.06
	1/17/2013	\$3,411.53
	2/28/2013	\$1,575.00
	2/28/2013	\$5,671.94
	3/31/2013	\$171.00
	3/31/2013	\$1,750.00
	4/22/2013	\$1,175.00
	5/31/2013	13,578.26
MEYER AND FLOWERS LLC	5/23/2013 Estate Claim	\$161.00
	6/28/2013	\$1,142.42
SMITH, HEMMESCH, BURKE, & KACZYNS	2/27/2013 Smith Parking Project	\$900.00
	3/31/2013 Smith Parking Project	\$300.00
	5/31/2013 Smith Parking Project	\$2,715.00
		<u>\$69,897.00</u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Smith Village# 0015032Report Period Beginning: 7/1/12Ending: 6/30/13**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 \$14,941
- (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. \$ 68,885 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. \$ 224,189  
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. \$ 52,560 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 132,006
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? No
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.