

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: <u>0015032</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Smith Village</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2024</u> to <u>6/30/2025</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>2320 West 113th Pl</u> <u>Chicago</u> <u>60643</u> Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>773-474-7300</u> Fax # <u>773-474-7302</u>																									
HFS ID Number: _____																									
Date of Initial License for Current Owners: <u>05/26/1926</u>		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Raymond Marneris</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Matthew Larsh</u> <u>Signing Director</u></td></tr><tr><td>(Firm Name & Address) <u>CLA (CliftonLarsonAllen LLP)</u> <u>833 West Lincoln Highway Suite 210W, Schererville, IN 4637</u></td></tr><tr><td>(Telephone) <u>630-368-3666</u> Fax # <u>219-864-0055</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Raymond Marneris</u>	(Title) <u>CFO</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Matthew Larsh</u> <u>Signing Director</u>	(Firm Name & Address) <u>CLA (CliftonLarsonAllen LLP)</u> <u>833 West Lincoln Highway Suite 210W, Schererville, IN 4637</u>	(Telephone) <u>630-368-3666</u> Fax # <u>219-864-0055</u>												
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Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td></td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.			☐ Trust			☐ Other _____	
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	☐ Limited Liability Co.																								
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630																							
Name: <u>Ema Araiza, Controoler</u> Telephone Number: <u>773-474-7344</u>																									
Email Address: _____																									

Facility Name & ID Number Smith Village # 0015032 Report Period Beginning: 7/1/2024 Ending: 6/30/2025

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	78	Skilled (SNF)	78	28,470	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	78	TOTALS	78	28,470	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	605					5,680	19,395	25,680	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	605					5,680	19,395	25,680	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 90.20%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

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 certified beds. number of certified beds _____

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025

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

STATE OF ILLINOIS

Facility Name & ID NumberSmith Village

#0015032

Report Period Beginning:7/1/2024

Ending:6/30/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	1,740,809	56,273	904,395	2,701,477		2,701,477	(1,624,984)	1,076,493			1
2	Food Purchase		1,339,447		1,339,447		1,339,447	(1,017,007)	322,440			2
3	Housekeeping	706,984	65,801	11,902	784,687		784,687	(462,125)	322,562			3
4	Laundry	175,370	28,432	34,290	238,092		238,092		238,092			4
5	Heat and Other Utilities			562,644	562,644		562,644	(453,807)	108,837			5
6	Maintenance	284,838	46,547	1,330,855	1,662,240		1,662,240	(1,355,294)	306,946			6
7	Other (specify):*											7
8	TOTAL General Services	2,908,001	1,536,500	2,844,086	7,288,587		7,288,587	(4,913,217)	2,375,370			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,017,954	140,440	3,516,012	5,674,406		5,674,406		5,674,406			10
10a	Therapy		65	1,008,793	1,008,858		1,008,858		1,008,858			10a
11	Activities	480,480	6,488	155,000	641,968		641,968	(56,856)	585,112			11
12	Social Services	110,967	(44)	436	111,359		111,359		111,359			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,609,401	146,949	4,710,241	7,466,591		7,466,591	(56,856)	7,409,735			16
	C. General Administration											
17	Administrative	174,583			174,583		174,583		174,583			17
18	Directors Fees											18
19	Professional Services			101,225	101,225		101,225	37,015	138,240			19
20	Dues, Fees, Subscriptions & Promotions			88,949	88,949	20,493	109,442		109,442			20
21	Clerical & General Office Expenses	337,659	21,498	2,521,728	2,880,885	(20,493)	2,860,392	(1,375,258)	1,485,134			21
22	Employee Benefits & Payroll Taxes			1,411,327	1,411,327		1,411,327	479,814	1,891,141			22
23	Inservice Training & Education			733	733		733		733			23
24	Travel and Seminar			16,996	16,996		16,996	11,124	28,120			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			636,938	636,938		636,938	(475,839)	161,099			26
27	Other (specify):*											27
28	TOTAL General Administration	512,242	21,498	4,777,896	5,311,636		5,311,636	(1,323,144)	3,988,492			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,029,644	1,704,947	12,332,223	20,066,814		20,066,814	(6,293,217)	13,773,597			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
 NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			963,435	963,435		963,435	(61,690)	901,745			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,882,787	1,882,787		1,882,787	(1,518,584)	364,203			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			94,734	94,734		94,734	(76,409)	18,325			35
36	Other (specify):*											36
37	TOTAL Ownership			2,940,956	2,940,956		2,940,956	(1,656,683)	1,284,273			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			462,392	462,392		462,392		462,392			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):* AL/IL/Marketing	906,654	2,682	3,217,686	4,127,022		4,127,022	(4,127,022)				43
44	TOTAL Special Cost Centers	906,654	2,682	3,680,078	4,589,414		4,589,414	(4,127,022)	462,392			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	6,936,298	1,707,629	18,953,257	27,597,184		27,597,184	(12,076,922)	15,520,262			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(161,609)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(9,122)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	18,768	30		9
10	Interest and Other Investment Income	(384,022)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(14,594)	6		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(87,682)	21		24
25	Fund Raising, Advertising and Promotional	(767,543)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule	(11,014,813)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,420,617)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	343,695	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 343,695		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (12,076,922)		37

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

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

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

NON-ALLOWABLE EXPENSES			Sch. V Line	
	Amount	Reference		
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	AL/IL dietary costs	(1,624,984)	1	3
4	AL/IL food purchases	(862,946)	2	4
5	AL/IL housekeeping	(462,125)	3	5
6	AL/IL heat & other utilities	(453,807)	5	6
7	AL/IL maintenance	(1,340,700)	6	7
8	AL/IL social service costs	(55,680)	11	8
9	AL/IL office & clerical	(639,556)	21	9
10	AL/IL insurance	(513,730)	26	10
11	AL/IL & Apt depreciation	(105,637)	30	11
12	AL/IL bond interest	(1,518,584)	32	12
13	AL/IL Equipment/Vehicle Rent	(76,409)	35	13
14	Life Enrichment Income	(1,176)	11	14
15				15
16	Direct AL/IL Costs	(3,359,479)	43	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	Total	(11,014,813)		49

Summary A

6/30/2025

[illegible]

Summary B

6/30/2025

[illegible]

VII. RELATED PARTIES

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

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

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

☐ 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	2	Food Purchases	\$	Smith Senior Living		\$ 7,548	\$ 7,548	1
2	V	19	Professional Serivces		Smith Senior Living		37,015	37,015	2
3	V	21	Clerical & General Office Exp		Smith Senior Living		1,671,792	1,671,792	3
4	V	22	PR Taxes & Employee Benefits		Smith Senior Living		479,814	479,814	4
5	V	24	Travel and Seminar		Smith Senior Living		11,124	11,124	5
6	V	26	Insurance		Smith Senior Living		37,891	37,891	6
7	V	30	Depreciation		Smith Senior Living		25,179	25,179	7
8	V								8
9	V								9
10	V	21	Management Fee	1,926,668				(1,926,668)	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,926,668			\$ 2,270,363	\$ * 343,695	14

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

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	Alice E. Keane	Chair		0.00					\$		1
2	Brian Piejko	Vice Chair		0.00							2
3	Tim Kelleher	Trustee		0.00							3
4	John Siegel	Trustee		0.00							4
5	Micheal P. Stanton	Trustee		0.00							5
6	William Waddell	Trustee		0.00							6
7	Anna Kaskins	Ex-officio		0.00							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: 7/1/2024 Ending: 5/30/2025

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 13th 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food Purchases	Direct Costs	59,861,062	2	\$ 16,372	\$	27,597,193	\$ 7,548	1
2	19	Professional Serivces	Direct Costs	59,861,062	2	80,290		27,597,193	37,015	2
3	21	Clerical & General Office Exp	Direct Costs	59,861,062	2	3,626,283		27,597,193	1,671,792	3
4	22	PR Taxes & Employee Benefits	Direct Costs	59,861,062	2	1,040,764		27,597,193	479,814	4
5	24	Travel and Seminar	Direct Costs	59,861,062	2	24,128		27,597,193	11,124	5
6	26	Insurance	Direct Costs	59,861,062	2	82,189		27,597,193	37,891	6
7	30	Depreciation	Direct Costs	59,861,062	2	54,616		27,597,193	25,179	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					\$ 4,924,642	\$		\$ 2,270,363	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10			
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense				
		YES	NO				Original	Balance							
	A. Directly Facility Related														
	Long-Term														
1	IHFA Series 2019A		X	Construction Loan			\$	22,030,800			\$	693,678	1		
2	IHFA Series 2019B		X	Refinance				25,000,000	20,289,000		0.0303	958,906	2		
3	IHFA Series 2019C		X	Refinance				5,119,000	4,472,000		0.0303	143,646	3		
4													4		
5													5		
	Working Capital														
6	Bond Amortization											86,557	6		
7													7		
8													8		
9	TOTAL Facility Related						\$	30,119,000	\$	46,791,800			\$	1,882,787	9
	B. Non-Facility Related*														
10													10		
11													11		
12													12		
13	AI/IL related Interest											(1,518,584)	13		
14	TOTAL Non-Facility Related						\$		\$				\$	(1,518,584)	14
15	TOTALS (line 9+line14)						\$	30,119,000	\$	46,791,800			\$	364,203	15

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

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

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

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 2024 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 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 9					
2021 10					
2022 11					
2023 12					
2024 13					
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

FACILITY NAME	<u>Smith Village</u>	COUNTY	<u>Cook</u>
---------------	----------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,896 B. General Construction Type: Exterior Brick Frame Masonry 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, 64,348 Square Feet - Costs adjusted out on page 5
Smith Village - 2320 West 113th Place, Smith Village Independent Living, 152 Units, 210,413 Square feet - Costs adjusted out on page 5

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. 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:

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

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	78			1992	\$ 4,868,578	\$	35	\$	\$	4
5				2022	19,088,233		40			5
6										6
7										7
8										8
	Improvement Type**									
9	2004 Improvements		2004	3,334		varies				9
10	2005 Improvements		2005	2,345		varies				10
11	2009 Improvements		2009	1,037,231		varies				11
12	2011 Improvements		2011	7,840		varies				12
13	2015 Improvements		2015	90,021		varies				13
14	2016 Improvements		2016	29,571		varies				14
15	2018 Improvements		2018	2,270		varies				15
16	2019 Improvements		2019	174,850		varies				16
17	2020 Improvements		2020	130,777		varies				17
18										18
19	AL Roof(\$258,700)		2024	65,296		20				19
20	Medical Waste Storage/Concrete Pads (\$19,375)		2025	4,890		5				20
21	Walk in Freezer (\$7,275)		2025	1,836		5				21
22	Pump Replacement (\$35,530)		2025	8,968		10				22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Total Building & Building Improvements Depreciation Expense				619,851		663,798		43,947	9,063,624
31	Add: HO Allocation				25,179				(25,179)	
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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	\$1,992,010	\$236,353	\$236,353	\$		\$924,931	71
72	Current Year Purchases	19,002						72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	\$2,011,012	\$236,353	\$236,353	\$		\$924,931	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	See Attached Schedule			\$40,896	\$1,593	\$1,593	\$		\$34,759	76
77										77
78										78
79										79
80	TOTALS			\$40,896	\$1,593	\$1,593	\$		\$34,759	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)	\$28,217,352	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$882,976	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$901,744	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$18,768	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$10,023,314	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	AL/IL Building & Building Improvements	\$63,246,120	\$1,840,685	\$28,547,761	86
87	Vehicles Non-SNF	121,132	4,719	102,955	87
88	AL/IL Equip	1,345,634	101,749	1,060,464	88
89					89
90					90
91	TOTALS	\$64,712,886	\$1,947,153	\$29,711,180	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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?
16. Rental Amount for movable equipment: \$94,734 Description: Dining Equipment, Furniture for Apartment staging
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☒ NO

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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

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	

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	4,011	\$ 399,422	\$	4,011	\$ 399,422	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,273	99,310		1,273	99,310	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		5,249	510,061	65	5,249	510,126	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				269,533		269,533	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Billable Supplies</u>	39-3					168,401		168,401	12
13	Other (specify): <u>Oxygen/Lab/Xray/RT</u>	39-3					24,458		24,458	13
14	TOTAL			\$	10,533	\$ 1,008,793	\$ 462,457	10,533	\$ 1,471,250	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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$1,761,513	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance158,613)	2,999,418		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	93,418		7
8	Accounts Receivable (owners or related parties)	(2,853,573)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$2,000,776	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,610,200		12
13	Land	2,222,867		13
14	Buildings, at Historical Cost	88,405,502		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,518,674		16
17	Accumulated Depreciation (book methods)	(39,734,496)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,420,490		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$66,443,237	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$68,444,013	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$2,849,326	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,231,000		29
30	Accrued Salaries Payable	657,683		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	97,131		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached	2,290,665		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$7,125,805	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	45,244,219		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest Rate Swap	(1,121,477)		43
44	See attached	22,699,510		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$66,822,252	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$73,948,057	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$(5,504,044)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$68,444,013	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,504,577)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,504,577)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,999,463)	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)	(4)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,999,467)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (5,504,044)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Smith Village

0015032

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,849,092	1
2	Discounts and Allowances for all Levels	(2,026,317)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,822,775	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,567,851	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,567,851	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,662	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	181,974	16
17	Sale of Drugs	255,423	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,150	19
20	Radiology and X-Ray	8,666	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 489,875	23
	D. Non-Operating Revenue		
24	Contributions	248,702	24
25	Interest and Other Investment Income***	623,842	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 872,544	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached	12,844,676	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,844,676	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 25,597,721	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	7,288,587	31
32	Health Care	7,466,591	32
33	General Administration	5,311,636	33
	B. Capital Expense		
34	Ownership	2,940,956	34
	C. Ancillary Expense		
35	Special Cost Centers	4,589,414	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 27,597,184	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,999,463)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,999,463)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 95,026.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	7,435,172.00	48
49	Medicare Part A	2,855,160.00	49
50	Other-(specify) Hospice/HMO/Managed Care	875,340.00	50
51	Other-(specify) C/A Ancillary	-1,437,923.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 9,822,775	56

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	1,755	1,950	\$ 128,270	\$ 65.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	61,058	66,026	1,566,133	23.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,021	2,317	58,761	25.36	8
9	Activity Director					9
10	Activity Assistants	19,491	21,911	480,480	21.93	10
11	Social Service Workers	2,970	3,270	110,967	33.94	11
12	Dietician					12
13	Food Service Supervisor	3,271	3,659	75,839	20.73	13
14	Head Cook	3,641	4,207	93,844	22.31	14
15	Cook Helpers/Assistants	64,179	68,143	1,291,229	18.95	15
16	Dishwashers	14,655	15,730	279,897	17.79	16
17	Maintenance Workers	8,538	9,405	284,838	30.29	17
18	Housekeepers	32,641	36,030	706,984	19.62	18
19	Laundry	8,181	9,064	175,370	19.35	19
20	Administrator	1,725	1,950	174,583	89.53	20
21	Assistant Administrator	1,713	1,950	75,402	38.67	21
22	Other Administrative	3,341	3,766	106,677	28.33	22
23	Office Manager					23
24	Clerical	8,865	9,321	155,580	16.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,533	10,679	264,790	24.80	31
32	Other Health Care: <u>AL Nursing</u>	28,640	30,967	734,545	23.72	32
33	Other(specify) <u>Marketing</u>	3,442	3,905	172,109	44.07	33
34	TOTAL (lines 1 - 33)	279,658	304,249	\$ 6,936,298 *	\$ 22.80	34

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		\$ 99,222	01-3	35
36	Medical Director		30,000	09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		1,555	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		3,451	10-.	44
45	Social Service Consultant		436	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 134,664		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	20,804	\$ 863,585	10-3	50
51	Licensed Practical Nurses	28,750	1,640,093	10-3	51
52	Certified Nurse Assistants/Aides	18,629	601,732	10-3	52
53	TOTAL (lines 50 - 52)	68,183	\$ 3,105,409		53

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

** See instructions.

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

LEADING AGE

Amount

23,500

23,500

Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

LEADING AGE

Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

LEADING AGE

23,500

23,500

Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense
and the location of this expense on Sch. V.

\$ 45,907

Line 10-2
- (6)

Have all costs reported on this form been determined using accounting procedures
consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period.

\$

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee?

Yes

If YES, attach an explanation of the allocation.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V.

\$ 95,169

Has any meal income been offset against
related costs?

Yes

Indicate the amount.

\$ 161,609
- (12)

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?

No

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other
times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report?

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
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name: CLA

Yes
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V?

Yes
- (15)

Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.