FOR BHF USE

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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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0046698

Facility Name: Smith Crossing

Address: 10501 Emilie (Number) Orland Park (City) 60467 (Zip Code)

County: Will

Telephone Number: (708 326-2300 **Fax #** (708) 326-2770

HFS ID Number:

Date of Initial License for Current Owners: 10/18/2005

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(C)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Raymond Marneris, CFO **Telephone Number:** (773) 747-7350
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/11 to 6/30/12 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.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Raymond Marneris
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Allan B. Larson, CPA, Partner
(Firm Name & Address) CliftonLarsonAllen LLP, 600 Washington Ave, Suite 1800, St. Louis MO 63101
(Telephone) (314) 925-4300 Fax # (314) 925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 12/1/12

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	30	Skilled (SNF)	46	14,388	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	30	TOTALS	46	14,388	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,603	6,616	3,089	12,308	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,603	6,616	3,089	12,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.54%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 10/18/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 30 and days of care provided 2,370

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2012 Fiscal Year: 6/30/2012

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	639,268	78,336	424,522	1,142,126		1,142,126	(768,398)	373,728			1
2	Food Purchase		654,658		654,658		654,658	(479,275)	175,383			2
3	Housekeeping	242,217	31,476	913	274,606		274,606	(235,377)	39,229			3
4	Laundry	23,885	12,829	12	36,726		36,726	(30,603)	6,123			4
5	Heat and Other Utilities			348,467	348,467		348,467	(290,373)	58,094			5
6	Maintenance	270,084	11,059	339,611	620,754		620,754	(519,184)	101,570			6
7	Other (specify):*											7
8	TOTAL General Services	1,175,454	788,358	1,113,525	3,077,337		3,077,337	(2,323,210)	754,127			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,009,818	43,406	944,059	1,997,283		1,997,283	(338,182)	1,659,101			10
10a	Therapy			234,056	234,056		234,056		234,056			10a
11	Activities	194,126	1,652	124,608	320,386		320,386	(271,571)	48,815			11
12	Social Services	59,113			59,113		59,113	(49,258)	9,855			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,263,057	45,058	1,314,723	2,622,838		2,622,838	(659,011)	1,963,827			16
	C. General Administration											
17	Administrative					114,261	114,261		114,261			17
18	Directors Fees											18
19	Professional Services			50,109	50,109		50,109	60,778	110,887			19
20	Dues, Fees, Subscriptions & Promotions			23,940	23,940		23,940	1,869	25,809			20
21	Clerical & General Office Expenses	253,903	12,603	1,078,404	1,344,910	(114,261)	1,230,649	(393,131)	837,518			21
22	Employee Benefits & Payroll Taxes			679,066	679,066		679,066	34,257	713,323			22
23	Inservice Training & Education			2,424	2,424		2,424		2,424			23
24	Travel and Seminar			14,033	14,033		14,033	11,575	25,608			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			87,167	87,167		87,167	(59,110)	28,057			26
27	Other (specify):*							(94,402)	(94,402)			27
28	TOTAL General Administration	253,903	12,603	1,935,143	2,201,649		2,201,649	(438,164)	1,763,485			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,692,414	846,019	4,363,391	7,901,824		7,901,824	(3,420,385)	4,481,439			29

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

Facility Name & ID Number Smith Crossing #0046698 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,440,335	1,440,335		1,440,335	(1,164,240)	276,095			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,712,009	1,712,009		1,712,009	(1,426,594)	285,415			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,915	7,915		7,915	(6,595)	1,320			35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,160,259	3,160,259		3,160,259	(2,597,429)	562,830			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			223,793	223,793		223,793		223,793			39
40	Barber and Beauty Shops			55,616	55,616		55,616	(55,616)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,418	35,418		35,418		35,418			42
43	Other (specify):* **Marketing**	185,117	1,909	102,197	289,223		289,223	(534,781)	(245,558)			43
44	**TOTAL Special Cost Centers**	185,117	1,909	417,024	604,050		604,050	(590,397)	13,653			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,877,531	847,928	7,940,674	11,666,133		11,666,133	(6,608,211)	5,057,922			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 Nun Smith Crossing **#** 0046698 **Report Period Beginning** 7/1/2011 **Ending:** 6/30/2012

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule		To Line	From Line
Reclassify administrator wages	$ 114,261	17	21

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	(38,940)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				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				24
25	Fund Raising, Advertising and Promotional	(289,223)	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 Supplemental Schedule	(6,190,981)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,519,144)		$	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)			34
35	Other- Attach Schedule	(89,067)	VII-B	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (89,067)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (6,608,211)		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.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Smith Crossing

ID# 0046698

Report Period Beginning: 7/1/11

Ending: 6/30/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL dietary costs	$ (768,398)	1	1
2	AL/IL food purchases	(440,440)	2	2
3	Guest room income	(6,552)	3	3
4	AL/IL housekeeping	(228,825)	3	4
5	AL/IL laundry	(30,603)	4	5
6	AL/IL heat & other utilities	(290,373)	5	6
7	AL/IL maintenance	(517,266)	6	7
8	Resident transport income	(1,918)	6	8
9	AL/IL nursing costs	(338,182)	10	9
10	AL/IL activities	(266,973)	11	10
11	Activities income	(4,598)	11	11
12	AL/IL Social Services	(49,258)	12	12
13	AL/IL Dues, fees, subs	(778)	20	13
14	AL/IL office & clerical	(19,811)	21	14
15	Miscellaneous income	(2,214)	21	15
16	Medication Setup income	(40,332)	21	16
17	Marketing employee benefits	(38,247)	22	17
18	AL/IL nursing & activities emp benefits	(44,517)	22	18
19	AL/IL travel & seminar	(84)	24	19
20	AL/IL insurance	(72,635)	26	20
21	Bank fees	(9,541)	27	21
22	Investment advisory fee	(3,856)	27	22
23	Other taxes and fees	(81,005)	27	23
24	AL/IL depreciation	(1,200,212)	30	24
25	AL/IL bond interest	(1,426,594)	32	25
26	AL/IL equipment rent	(6,595)	35	26
27	Beauty shop income	(55,616)	40	27
28	Amort costs of acquiring continuing care contracts	(122,817)	43	28
29	Remove credit - interdepartment transfer	(122,741)	43	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**	(6,190,981)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Crossing # 0046698 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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	(768,398)	0	0	0	0	0	0	0	0	0	0	(768,398)	1
2	Food Purchase	(479,380)	105	0	0	0	0	0	0	0	0	0	(479,275)	2
3	Housekeeping	(235,377)	0	0	0	0	0	0	0	0	0	0	(235,377)	3
4	Laundry	(30,603)	0	0	0	0	0	0	0	0	0	0	(30,603)	4
5	Heat and Other Utilities	(290,373)	0	0	0	0	0	0	0	0	0	0	(290,373)	5
6	Maintenance	(519,184)	0	0	0	0	0	0	0	0	0	0	(519,184)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,323,315)	105	0	0	0	0	0	0	0	0	0	(2,323,210)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(338,182)	0	0	0	0	0	0	0	0	0	0	(338,182)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(271,571)	0	0	0	0	0	0	0	0	0	0	(271,571)	11
12	Social Services	(49,258)	0	0	0	0	0	0	0	0	0	0	(49,258)	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	**TOTAL Health Care and Programs**	(659,011)	0	0	0	0	0	0	0	0	0	0	(659,011)	16
	C. General Administration													
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	60,778	0	0	0	0	0	0	0	0	0	60,778	19
20	Fees, Subscriptions & Promotions	(778)	2,647	0	0	0	0	0	0	0	0	0	1,869	20
21	Clerical & General Office Expenses	(62,357)	(330,774)	0	0	0	0	0	0	0	0	0	(393,131)	21
22	Employee Benefits & Payroll Taxes	(82,764)	117,021	0	0	0	0	0	0	0	0	0	34,257	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(84)	11,659	0	0	0	0	0	0	0	0	0	11,575	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(72,635)	13,525	0	0	0	0	0	0	0	0	0	(59,110)	26
27	Other (specify):*	(94,402)	0	0	0	0	0	0	0	0	0	0	(94,402)	27
28	**TOTAL General Administration**	(313,020)	(125,144)	0	0	0	0	0	0	0	0	0	(438,164)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,295,346)	(125,039)	0	0	0	0	0	0	0	0	0	(3,420,385)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Crossing # 0046698 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(1,200,212)	35,972	0	0	0	0	0	0	0	0	0	(1,164,240)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,426,594)	0	0	0	0	0	0	0	0	0	0	(1,426,594)	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	(6,595)	0	0	0	0	0	0	0	0	0	0	(6,595)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,633,401)	35,972	0	0	0	0	0	0	0	0	0	(2,597,429)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(55,616)	0	0	0	0	0	0	0	0	0	0	(55,616)	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):*	(534,781)	0	0	0	0	0	0	0	0	0	0	(534,781)	43
44	**TOTAL Special Cost Centers**	(590,397)	0	0	0	0	0	0	0	0	0	0	(590,397)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,519,144)	(89,067)	0	0	0	0	0	0	0	0	0	(6,608,211)	45

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 Village	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. [X] 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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food Purchases	$	Smith Senior Living		$ 105	$ 105	1
2	V	19	Professional Serivces		Smith Senior Living		60,778	60,778	2
3	V	20	Fees and Subscriptions		Smith Senior Living		2,647	2,647	3
4	V	21	Clerical & General Office Exp		Smith Senior Living		575,304	575,304	4
5	V	22	PR Taxes & Employee Benefits		Smith Senior Living		117,021	117,021	5
6	V	24	Travel and Seminar		Smith Senior Living		11,659	11,659	6
7	V	26	Insurance		Smith Senior Living		13,525	13,525	7
8	V	30	Depreciation		Smith Senior Living		35,972	35,972	8
9	V							0	9
10	V							0	10
11	V	21	Management Fees	906,078				(906,078)	11
12	V								12
13	V								13
14	Total			$ 906,078			$ 817,011	$ * (89,067)	14

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Thomas E. Chomicz	Board Member	Trustee of the	None	788			Legal Serivce	$ 1,641	19.3	1
2			Board and Partner		Smith Village						2
3			at Quarles & Brady								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 1,641		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 Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food Purchases	Direct Costs	30,947,925	2	$ 301	$	11,665,530	$ 113	1
2	19	Professional Serivces	Direct Costs	30,947,925	2	174,843		11,665,530	65,905	2
3	20	Fees and Subscriptions	Direct Costs	30,947,925	2	7,616		11,665,530	2,871	3
4	21	Clerical & General Office Exp	Direct Costs	30,947,925	2	1,655,012	1,432,481	11,665,530	623,841	4
5	22	PR Taxes & Employee Benefits	Direct Costs	30,947,925	2	336,643		11,665,530	126,894	5
6	24	Travel and Seminar	Direct Costs	30,947,925	2	33,541		11,665,530	12,643	6
7	26	Insurance	Direct Costs	30,947,925	2	38,907		11,665,530	14,666	7
8	30	Depreciation	Direct Costs	30,947,925	2	103,481		11,665,530	39,006	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					$ 2,350,344	$ 1,432,481		$ 885,939	25

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	Bond - Series 2003A		X	Facility Construction	N/A	11/1/2003	$ 20,110,000	$ 18,470,000	11/15/2032	Variable	$ 1,434,737	1
2	Bond - Series 2003B-2		X	Facility Construction	N/A	11/1/2003	4,250,000	4,113,000	11/15/2033	0.0525	277,272	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 24,360,000	$ 22,583,000			$ 1,712,009	9
	B. Non-Facility Related*											
10	Remove AL/IL portion of Interest Expense											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 24,360,000	$ 22,583,000			$ 1,712,009	15

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

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

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

Facility Name & ID Number Smith Crossing # 0046698 **Report Period Beginning:** 7/1/11 **Ending:** 6/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2007	8
	2008	9
	2009	10
	2010	11
	2011	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Smith Crossing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046698

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 2011 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 2011.

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

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 208,677 B. General Construction Type: Exterior Brick/Siding Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (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? [X] (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 Crossing, Independent Living - 149,119 square feet - 97 units
Smith Crossing, Assisted Living - 19,704 square feet, 48 units
Smith Crossing is a CCRC which includes the nursing facility and services listed above. All non- nursing facility costs have been adjusted out on page 5 and 5A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2001	$ 6,452,639	1
2					2
3	TOTALS			$ 6,452,639	3

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	30			2005	$ 39,226,430	$ 1,072,326	40	$ 1,072,326	$	$ 7,497,637	4
5	16			2012	7,235,761	201,329	20	201,329	0	201,329	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	11,062	1,111	10	1,111		7,777	9
10	Various			2006	151,005	16,627	10	16,627		85,383	10
11	Various			2007	51,851	7,325	10	7,325		38,266	11
12	Flooring America - Carpeting - H2			2008	1,127	225	5	225		1,127	12
13	Flooring America - Carpeting - 2104			2008	3,723	745	5	745		3,662	13
14	Flooring America - Hardwood Flooring - 10410/10418/10420			2008	17,804	1,780	10	1,780		8,457	14
15	Flooring America - Carpeting 1209 / 2303			2008	8,101	1,620	5	1,620		7,291	15
16	Flooring America - Carpeting - 1403 / 1410			2008	2,790	558	5	558		2,511	16
17	Flooring America - Carpeting - 2410			2008	1,263	253	5	253		1,116	17
18	Flooring America - Vinyl Flooring - 1405 Kitchen			2008	626	63	10	63		277	18
19	Flooring America - Carpeting - 1413 / 1405 / 2306			2008	5,829	1,166	5	1,166		5,149	19
20	Flooring America - Carpeting - 2409			2008	1,728	346	5	346		1,521	20
21	Flooring America - Carpeting - 2405 / 3204			2008	6,183	1,237	5	1,237		5,359	21
22	Flooring America - Carpeting - 2405 / 3204			2008	2,127	425	5	425		1,843	22
23	Flooring America - Carpeting - Cottage 10430			2008	9,954	1,991	5	1,991		8,295	23
24	Flooring America - Carpeting - 2407			2008	2,493	499	5	499		2,078	24
25	Flooring America - Carpeting - 2202 / 1414/ 1203			2008	11,730	2,346	5	2,346		9,580	25
26	AG Architecture - Screen Porch			2008	5,718	1,143	5	1,143		4,478	26
27	AG Architecture - Add Elevators to Existing Generator			2008	3,690	185	20	185		692	27
28	Creative Carpet - 2403			2008	1,076		10			1,076	28
29	Creative Carpet - 10410			2008	1,945	389	5	389		1,524	29
30	Creative Carpet - 2206			2008	3,257	326	10	326		1,276	30
31	Creative Carpet - 10408			2008	2,581	516	5	516		2,021	31
32	Creative Carpet - 1415			2008	534	107	5	107		410	32
33	Creative Carpet - 2206			2008	1,994	398	5	398		1,528	33
34	Creative Carpet - 1308			2008	1,912	382	5	382		1,434	34
35	Creative Carpet - 1406			2008	1,010		5			1,010	35
36	Creative Carpet - 10430			2008	578	58	10	58		212	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	
37	Creative Carpet - 3207	2008	$ 1,927	$ 385	5	$ 385	$	$ 1,413	37
38	Creative Carpet - 3203	2008	2,924	585	5	585		2,096	38
39	Creative Carpet - 2208	2009	1,336	267	5	267		935	39
40	Creative Carpet - J1	2009	548	110	5	110		375	40
41	Creative Carpet - 2401	2009	1,041	208	5	208		711	41
42	Creative Carpet - 2411	2009	1,085	217	5	217		741	42
43	Creative Carpet - 1108	2009	1,232	246	5	246		841	43
44	Creative Carpet	2009	689	138	5	138		459	44
45	Creative Carpet	2009	689	138	5	138		460	45
46	Creative Carpet - 3104	2009	1,989	398	5	398		1,326	46
47	Creative Carpet - 2404	2009	1,048	210	5	210		699	47
48	Creative Carpet	2009	306	61	5	61		204	48
49	Creative Carpet - 2408	2009	528	106	5	106		343	49
50	Creative Carpet - 1407	2009	516	103	5	103		327	50
51	Creative Carpet - 2104	2009	1,577	315	5	315		972	51
52	Flooring America - Carpet - 3103	2009	5,078	1,016	5	1,016		3,555	52
53	J&L Metal Doors - Fire Exit Door Hardware	2009	1,631	163	5	163		598	53
54	Ronald anerson - Paint 10408	2009	7,400	1,480	5	1,480		5,673	54
55	The Geo Group - Villas - Enclosed 3 Season Porches	2009	32,000	6,400	5	6,400		21,333	55
56	The Geo Group - Villas - Enclosed 3 Season Porches	2009	50,730	10,146	5	10,146		33,820	56
57	The Geo Group - Villas - Enclosed 3 Season Porches	2009	900	180	5	180		600	57
58	McCabe - Carpeting	2009	2,000	400	5	400		1,183	58
59	Creative Carpet	2009	5,501	1,100	5	1,100		2,692	59
60	Creative Carpet	2010	21,758	4,352	5	4,352		9,608	60
61	Greenway Landscape Nursery	2010	29,464	2,946	5	2,946		6,752	61
62	Home Depot Supply	2010	1,393	139	7	139		400	62
63	2-Wire System	2011	20,000	2,000	10	2,000		2,167	63
64	Carpeting	2011	30,356	6,071	5	6,071		8,708	64
65	Landscapting	2011	135	26	5	26		52	65
66	Dyrwall and painting	2011	1,800	360	5	360		465	66
67	Marketing Area Enclosure	2011	3,911	782	5	782		782	67
68	Remove and repair sidewalks	2011	2,600	130	20	130		168	68
69	Vinyl	2012	681	131	5	131		131	69
70	TOTAL (lines 4 thru 69)		$ 47,010,655	$ 1,356,784		$ 1,356,784	$ 0	$ 8,014,908	70

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

STATE OF ILLINOIS

Facility Name & ID Numbe Smith Crossing # 0046698 Report Period Beginning:

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	
1	Totals from Page 12A, Carried Forward		$ 47,010,655	$ 1,356,784		$ 1,356,784	$
2	Carpeting	2012	42,476	4,274	5	4,274	
3	Thermocore Door	2012	4,016	385	10	385	
4	Sprinkler Repair	2012	6,057	1,161	5	1,161	
5	Fountain Winterizing	2012	300	38	5	38	
6	SC Phase 2A	2012	194,994	8,125	15	8,125	
7	SC Phase 2C	2012	358,943	13,115	15	13,115	
8	Spring Fountain Install/Sprinkler Repair	2012	3,850	160	5	160	
9	Sprinkler Repair	2012	844	7	5	7	
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24	Adjustment - Remove allocated Assisted & Independent Living depreciation expense						
25	Adjustment - Add Smith Senior Living allocated depreciation expense						
26	Adjustment - Remove Home Office depreciation expense allocated to Assisted & Independent Living						
27							
28							
29							
30							

31							
32							
33							
34	**TOTAL (lines 1 thru 33)**		**$ 47,622,136**	**$ 1,384,048**		**$ 1,384,049**	**$**

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

7/1/2011 Ending: 6/30/2012

8 Adjustments	9 Accumulated Depreciation	
0	$ 8,014,908	1
0	4,274	2
0	385	3
0	1,161	4
0	38	5
0	8,125	6
0	13,115	7
0	160	8
0	7	9
		10
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0	$ 8,042,172	34

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	$ 1,330,700	$ 24,940	$ 24,940	$	Various	$ 500,772	71
72	Current Year Purchases	443,687	24,607	24,607		Various	25,666	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,774,387	$ 49,547	$ 49,547	$		$ 526,438	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	CCRC	Passenger Bus	2004	$ 61,437	$	$	$	5	$ 61,437	76
77	CCRC	2000 Ford Pickup	2005	13,933				5	13,933	77
78	CCRC	Chevy Impala	2006	19,535				5	19,535	78
79	CCRC	Passenger Bus	2011	71,883	6,739	6,739		15	13,478	79
80	TOTALS			$ 166,788	$ 6,739	$ 6,739	$		$ 108,383	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)	$ 55,404,469	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,440,334	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,440,335	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,649,729	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Phase 2 Reconstruction	$ 19,724,171	92
93			93
94			94
95		$ 19,724,171	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.

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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: *

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.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	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 Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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
   - [X] 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 ____

CNA's have received training and certification prior to being hired with Smith Crossing.

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10.3	hrs	$	1,575	$ 103,087	$	1,575	$ 103,087	1
2	Licensed Speech and Language Development Therapist	10.3	hrs		310	31,923		310	31,923	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10.3	hrs		1,508	99,026		1,508	99,026	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	3,393	$ 234,036	$	3,393	$ 234,036	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.

STATE OF ILLINOIS

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,979,586	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 32,624)	703,497		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,889		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,779,972	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,280,016		12
13	Land	6,452,639		13
14	Buildings, at Historical Cost	47,414,611		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,956,769		16
17	Accumulated Depreciation (book methods)	(8,830,900)		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 (spe **Bond Funds**	28,658,541		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 77,931,676	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 80,711,648	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,789,593	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	250,983		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	147,745		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	5,541,392		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 12,729,713	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	40,533,256		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	27,806,982		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 68,340,238	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 81,069,951	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (358,303)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 80,711,648	$	48

*(See instructions.)

SCHEDULE XV. BALANCE SHEET - Supplemental Schedule

Line 36 - Other Current Liabilities

Description	Amount
Resident credit balances	$ 99,356
Deposits-AL/Skilled	$ 309,078
Deposits - IL Wait List	$ 32,637
Deposists - IL Closings	$ 20,290
Deposit Escrow Liability	$ 1,857,440
IC - Due to/from Related	$ 3,222,591
	$ 5,541,392

Line 43 - Other Long-Term Liabilities

Description	Amount
Note payable to affiliate - Smith Senior Living	$ 3,000,000
Refundable entrance fees	23,255,389
Deferred revenue from non-refundable entrance fees	1,551,593
	$ 27,806,982

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 928,638	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 928,638	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,286,941)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,286,941)	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)**	$ (358,303)	24 *

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,449,048	1
2	Discounts and Allowances for all Levels	(1,124,746)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,324,302	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	491,553	6
7	Oxygen	(10)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 491,543	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	60,529	13
14	Non-Patient Meals	73,537	14
15	Telephone, Television and Radio	55,141	15
16	Rental of Facility Space	24,933	16
17	Sale of Drugs	102,899	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,145	19
20	Radiology and X-Ray	8,239	20
21	Other Medical Services	143,405	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 494,828	23
	D. Non-Operating Revenue		
24	Contributions	8,677	24
25	Interest and Other Investment Income***	10,780	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,457	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	49,062	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 49,062	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,379,192	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,077,337	31
32	Health Care	2,243,339	32
33	General Administration	2,581,148	33
	B. Capital Expense		
34	Ownership	3,160,259	34
	C. Ancillary Expense		
35	Special Cost Centers	279,409	35
36	Provider Participation Fee	35,418	36
	D. Other Expenses (specify):		
37	Marketing Expense	289,223	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,666,133	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,286,941)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,286,941)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 400,656	44
45	Private Pay - Net Inpatient Revenue	8,270,045	45
46	Medicare - Net Inpatient Revenue	582,244	46
47	Other-(specify) Hospice	71,357	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,324,302	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.**

SCHEDULE XVII. INCOME STATEMENT - Supplemental Schedule

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.

Line 28 Other Revenue

Description	Amount
Resident transport - private pay	$ 1,918
Miscellaneous income	2,214
Activities income	4,598
Medication Setup / Admin	40,332
	$ 49,062

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	1,987	$ 84,533	$ 42.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,361	1,344	38,323	28.51	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	64,914	64,488	816,480	12.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	1,994	34,139	17.12	9
10	Activity Assistants	11,515	11,382	150,363	13.21	10
11	Social Service Workers	2,028	1,987	58,332	29.36	11
12	Dietician					12
13	Food Service Supervisor		1,979	24,921	12.59	13
14	Head Cook	17,573	14,470	186,406	12.88	14
15	Cook Helpers/Assistants	43,152	42,983	418,484	9.74	15
16	Dishwashers					16
17	Maintenance Workers	15,337	15,197	227,643	14.98	17
18	Housekeepers	26,766	29,576	309,480	10.46	18
19	Laundry	2,071	2,062	19,881	9.64	19
20	Administrator	2,080	1,987	114,261	57.50	20
21	Assistant Administrator					21
22	Other Administrative	9,816	9,759	123,192	12.62	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Nursing Mngt	6,987	6,891	81,775	11.87	32
33	Other(specify) Marketing	9,087	8,965	189,318	21.12	33
34	TOTAL (lines 1 - 33)	216,847	217,051	$ 2,877,531 *	$ 13.26	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				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	4	248	11.3	44
45	Social Service Consultant	32	1,984	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	36	$ 2,232		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	39	$ 2,075	10.3	50
51	Licensed Practical Nurses	37	1,436	10.3	51
52	Certified Nurse Assistants/Aides	28	675	10.3	52
53	TOTAL (lines 50 - 52)	104	$ 4,186		53

POLSINELLI SHUGHART	7/31/2011	CON Compliance Issue/IDPH	$1,359.48
	8/31/2011	CON Compliance Issue/IDPH	$2,572.71
	9/30/2011	ICC issue and permit renewal	$194.00
	9/30/2011	POC and smoke detection/progress of new SNF unit/permit renewal	$1,131.50
	10/31/2011	Survey for new facility/response to POC and FSES	$2,450.00
	12/31/2011	CON Compliance Issue/IDPH	$3,085.00
	3/22/2012	General/Life safety code survey/IDPH Fine (type A violation)	$6,176.00
	4/24/2012	Regarding DPNA from CMS	$3,684.95
QUARLES & BRADY, LLC	8/31/2011	Washington and Jane Smith Community -review of revised title endorsements	$313.90
	2/29/2012	Registration maintenance deadline	$171.00
	3/22/2012	Declaration of Use & Incontstability	$1,068.00
HINSHAW & CULBERTSON LLP	5/11/2012	SC labor and Employment matter - union prevention	$1,575.00
	6/13/2012	SC labor and Employment matter - analysis of employee complaints/ union assessment	$1,800.00
	5/31/2012	Pamela Evans - NLRB charge	$2,564.30
			$28,145.84
		Account No. 130-5410-8020	28,147
		Difference	($1.16)

0046698	Report Period Beginning:	7/1/2011	Ending:	6/30/2012

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Frank Guajardo	Executive Director	0	$ 114,261
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,261

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Hinshaw & Culbertson	Legal Services	$ 5,939
Polsinelli Shughart PC	Legal Services	20,654
Quarels & Brady LLP	Legal Services	1,554
Paylocity	Payroll Service	10,162
Chessboard Consulting	Climate Assessment	11,800
Add: Home Office allocation		60,778
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 110,887

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,708
Unemployment Compensation Insurance	0
FICA Taxes	209,044
Employee Health Insurance	289,414
Employee Meals	38,940
Illinois Municipal Retirement Fund (IMRF)*	0
Disability insurance	3,094
Life insurance	1,805
Pension / 401K	45,369
PTO Used / Not Paid	18,692
Less: Non-allowed AL/IL employee benefits	(44,517)
Less: Non-allowed Marketing employee benefits	(38,247)
Add: Home Office employee benefits	117,021
TOTAL (agree to Schedule V, line 22, col.8)	$ 713,323

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	10,314
(Indicate # of checks performed)	
Dues & Memberships	5,771
Subscriptions	961
Association Dues	6,894
Less: Non-allowed AL/IL costs	(778)
Add: Home Office allocation	2,647
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,809

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	3,614
Seminar Expense	10,419
Less: Non-allowed AL/IL expenses	(84)
Add: Home Office allocation	11,659
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 25,608

**See instructions.

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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	Amount of Expense Amortized Per Year								
					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	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/11 Ending: 6/30/12

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 $6,894**

(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? **5-7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,264** 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. $ **35,418**
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? **Yes (ALIL)** 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. $ **38,940** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **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.