FOR BHF USE

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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: 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
  - [X] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code 501(C)(3)
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] 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 07/01/2014 to 06/30/2015 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) Deborah Freeland, Principal
(Firm Name & Address) CliftonLarsonAllen LLP, 9365 Counselors Row, Suite 200, Indianapolis, IN 46240
(Telephone) (317) 569-6230 Fax # (317) 574-9707

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: 07/01/2014 Ending: 06/30/2015

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 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	46	Skilled (SNF)	46	16,790	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	46	TOTALS	46	16,790	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	1,455	7,251	6,307	15,013	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,455	7,251	6,307	15,013	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.42%

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 10/15/2005

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 46 and days of care provided 6,307

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: 6/30/2015 Fiscal Year: 6/30/2015

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	882,328	102,893	514,546	1,499,767		1,499,767	(1,261,938)	237,829			1
2	Food Purchase		976,178		976,178		976,178	(863,732)	112,446			2
3	Housekeeping	347,987	31,764	13,554	393,305		393,305	(334,820)	58,485			3
4	Laundry	61,286	12,063	208	73,557		73,557	(61,294)	12,263			4
5	Heat and Other Utilities			489,669	489,669		489,669	(408,035)	81,634			5
6	Maintenance	204,680	16,395	641,293	862,368		862,368	(719,653)	142,715			6
7	Other (specify):*											7
8	TOTAL General Services	1,496,281	1,139,293	1,659,270	4,294,844		4,294,844	(3,649,472)	645,372			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	1,074,701	96,848	1,301,702	2,473,251		2,473,251	(774,687)	1,698,564			10
10a	Therapy			656,072	656,072		656,072		656,072			10a
11	Activities	253,489	3,143	139,430	396,062		396,062	(337,858)	58,204			11
12	Social Services	64,527	4,151	822	69,500		69,500	(57,913)	11,587			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,392,717	104,142	2,109,026	3,605,885		3,605,885	(1,170,458)	2,435,427			16
	C. General Administration											
17	Administrative					133,505	133,505		133,505			17
18	Directors Fees											18
19	Professional Services			45,735	45,735		45,735	13,395	59,130			19
20	Dues, Fees, Subscriptions & Promotions			39,533	39,533		39,533	(1,250)	38,283			20
21	Clerical & General Office Expenses	311,014	4,557	1,651,072	1,966,643	(133,505)	1,833,138	(648,471)	1,184,667			21
22	Employee Benefits & Payroll Taxes			795,844	795,844		795,844	186,507	982,351			22
23	Inservice Training & Education			251	251		251		251			23
24	Travel and Seminar			6,376	6,376		6,376	22,296	28,672			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			196,626	196,626		196,626	(137,320)	59,306			26
27	Other (specify):*											27
28	TOTAL General Administration	311,014	4,557	2,735,437	3,051,008		3,051,008	(564,843)	2,486,165			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,200,012	1,247,992	6,503,733	10,951,737		10,951,737	(5,384,773)	5,566,964			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:** 07/01/2014 **Ending:** 06/30/2015

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule

		To Line	From Line
Reclassify administrator wages	$ 133,505	17	21

Facility Name & ID Number Smith Crossing #0046698 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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			3,084,465	3,084,465		3,084,465	(2,527,173)	557,292			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,445,193	1,445,193		1,445,193	(1,014,727)	430,466			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,114	19,114		19,114	(15,927)	3,187			35
36	Other (specify):*											36
37	**TOTAL Ownership**			4,548,772	4,548,772		4,548,772	(3,557,827)	990,945			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			406,787	406,787		406,787		406,787			39
40	Barber and Beauty Shops		15,150	93,866	109,016		109,016	(38,910)	70,106			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,185	25,185		25,185		25,185			42
43	Other (specify):* **Marketing**	190,965	9,570	808,353	1,008,888		1,008,888	(1,008,888)				43
44	**TOTAL Special Cost Centers**	190,965	24,720	1,334,191	1,549,876		1,549,876	(1,047,798)	502,078			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,390,977	1,272,712	12,386,696	17,050,385		17,050,385	(9,990,398)	7,059,987			45

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(47,879)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,828)	21		5
6	Rented Facility Space	(7,084)	3		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	(227,452)	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)	(1,096)	6		16
17	Non-Care Related Fees	(7,822)	11		17
18	Fines and Penalties	(2,358)	21		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	(88,734)	21		24
25	Fund Raising, Advertising and Promotional	(1,008,888)	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**	(8,712,170)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,105,311)		$	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	114,913	VII-B	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 114,913		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (9,990,398)		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

STATE OF ILLINOIS **Page 5A**

Smith Crossing

ID# 0046698

Report Period Beginning: 07/01/2014

Ending: 06/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL dietary costs	$ (1,261,938)	1	1
2	AL/IL food purchases	(821,378)	2	2
3	AL/IL housekeeping	(327,736)	3	3
4	AL/IL laundry	(61,294)	4	4
5	AL/IL heat & other utilities	(408,035)	5	5
6	AL/IL maintenance	(718,413)	6	6
7	AL/IL nursing costs	(774,687)	10	7
8	AL/IL activities	(330,033)	11	8
9	AL/IL Social Services	(57,913)	12	9
10	AL/IL Dues, fees, subs	(1,250)	20	10
11	AL/IL office & clerical	(35,127)	21	11
12	Miscellaneous income	(1,748)	21	12
13	Medication Setup income	(16,048)	21	13
14	AL/IL nursing & activities emp benefits	(92,770)	22	14
15	AL/IL travel & seminar	0	24	15
16	AL/IL insurance	(163,846)	26	16
17	AL/IL depreciation	(2,570,243)	30	17
18	AL/IL bond interest	(1,014,727)	32	18
19	AL/IL equipment rent	(15,927)	35	19
20	Beauty shop income	(38,910)	40	20
21	Maintenance Late Fees	(144)	6	21
22	Activities Late Fees	(3)	11	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**	(8,712,170)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Crossing # 0046698 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	(1,261,938)	0	0	0	0	0	0	0	0	0	0	(1,261,938)	1
2	Food Purchase	(869,257)	5,525	0	0	0	0	0	0	0	0	0	(863,732)	2
3	Housekeeping	(334,820)	0	0	0	0	0	0	0	0	0	0	(334,820)	3
4	Laundry	(61,294)	0	0	0	0	0	0	0	0	0	0	(61,294)	4
5	Heat and Other Utilities	(408,035)	0	0	0	0	0	0	0	0	0	0	(408,035)	5
6	Maintenance	(719,653)	0	0	0	0	0	0	0	0	0	0	(719,653)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,654,997)	5,525	0	0	0	0	0	0	0	0	0	(3,649,472)	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	(774,687)	0	0	0	0	0	0	0	0	0	0	(774,687)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(337,858)	0	0	0	0	0	0	0	0	0	0	(337,858)	11
12	Social Services	(57,913)	0	0	0	0	0	0	0	0	0	0	(57,913)	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**	(1,170,458)	0	0	0	0	0	0	0	0	0	0	(1,170,458)	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	13,395	0	0	0	0	0	0	0	0	0	13,395	19
20	Fees, Subscriptions & Promotions	(1,250)	0	0	0	0	0	0	0	0	0	0	(1,250)	20
21	Clerical & General Office Expenses	(373,295)	(275,176)	0	0	0	0	0	0	0	0	0	(648,471)	21
22	Employee Benefits & Payroll Taxes	(92,770)	279,277	0	0	0	0	0	0	0	0	0	186,507	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	22,296	0	0	0	0	0	0	0	0	0	22,296	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(163,846)	26,526	0	0	0	0	0	0	0	0	0	(137,320)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(631,161)	66,318	0	0	0	0	0	0	0	0	0	(564,843)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,456,616)	71,843	0	0	0	0	0	0	0	0	0	(5,384,773)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Crossing # 0046698 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

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	(2,570,243)	43,070	0	0	0	0	0	0	0	0	0	(2,527,173)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,014,727)	0	0	0	0	0	0	0	0	0	0	(1,014,727)	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	(15,927)	0	0	0	0	0	0	0	0	0	0	(15,927)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,600,897)	43,070	0	0	0	0	0	0	0	0	0	(3,557,827)	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	(38,910)	0	0	0	0	0	0	0	0	0	0	(38,910)	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):*	(1,008,888)	0	0	0	0	0	0	0	0	0	0	(1,008,888)	43
44	**TOTAL Special Cost Centers**	(1,047,798)	0	0	0	0	0	0	0	0	0	0	(1,047,798)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,105,311)	114,913	0	0	0	0	0	0	0	0	0	(9,990,398)	45

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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. ☐ 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		$ 5,525	$ 5,525	1
2	V	19	Professional Serivces		Smith Senior Living		13,395	13,395	2
3	V	21	Clerical & General Office Exp		Smith Senior Living		1,038,359	1,038,359	3
4	V	22	PR Taxes & Employee Benefits		Smith Senior Living		279,277	279,277	4
5	V	24	Travel and Seminar		Smith Senior Living		22,296	22,296	5
6	V	26	Insurance		Smith Senior Living		26,526	26,526	6
7	V	30	Depreciation		Smith Senior Living		43,070	43,070	7
8	V								8
9	V								9
10	V								10
11	V	21	Management Fees	1,313,535				(1,313,535)	11
12	V								12
13	V								13
14	Total			$ 1,313,535			$ 1,428,448	$ * 114,913	14

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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	See attached board listing							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: 07/01/2014 Ending: 06/30/2015

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

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

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2014 Ending: 6/30/2015

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	37,739,896	2	$ 12,229	$	17,050,390	$ 5,525	1
2	19	Professional Serivces	Direct Costs	37,739,896	2	29,649		17,050,390	13,395	2
3	21	Clerical & General Office Exp	Direct Costs	37,739,896	2	2,298,338	1,681,569	17,050,390	1,038,359	3
4	22	PR Taxes & Employee Benefits	Direct Costs	37,739,896	2	618,160		17,050,390	279,277	4
5	24	Travel and Seminar	Direct Costs	37,739,896	2	49,350		17,050,390	22,296	5
6	26	Insurance	Direct Costs	37,739,896	2	58,713		17,050,390	26,526	6
7	30	Depreciation	Direct Costs	37,739,896	2	95,332		17,050,390	43,070	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					$ 3,161,771	$ 1,681,569		$ 1,428,448	25

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3	Bond - Series 2013A		X	Construction/Refinance	N/A	11/8/2013	23,600,000	21,817,598	11/15/2038	Variable	852,766	3
4	Bond - Series 2013B		X	Construction/Refinance	N/A	11/8/2013	16,400,000	15,161,459	11/15/2038	Variable	591,030	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 40,000,000	$ 36,979,057			$ 1,443,796	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	See Supplemental Schedule										(1,014,727)	13
14	TOTAL Non-Facility Related						$	$			$ (1,014,727)	14
15	TOTALS (line 9+line14)						$ 40,000,000	$ 36,979,057			$ 429,069	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:** 07/01/2014 **Ending:** 06/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Smith Crossing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046698

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 07/01/2014 Ending: 06/30/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 208,677 B. General Construction Type: Exterior Brick/Siding Frame Masonry 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 [ ] 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: 07/01/2014 Ending: 06/30/2015

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	$	40	$	$	$	4
5	16			2012	7,235,761		20				5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	351		10				9
10	Various			2006	2,307		10				10
11	Various			2007	3,735		10				11
12	Flooring America - Hardwood Flooring - 10410/10418/10420			2008	17,804		10				12
13	AG Architecture - Screen Porch			2008	5,718		5				13
14	AG Architecture - Add Elevators to Existing Generator			2008	3,690		20				14
15	J&L Metal Doors - Fire Exit Door Hardware			2009	1,631		5				15
16	The Geo Group - Villas - Enclosed 3 Season Porches			2009	32,000		5				16
17	The Geo Group - Villas - Enclosed 3 Season Porches			2009	50,730		5				17
18	The Geo Group - Villas - Enclosed 3 Season Porches			2009	900		5				18
19	Greenway Landscape Nursery			2010	29,464		5				19
20	Home Depot Supply			2010	1,393		7				20
21	2-Wire System			2011	20,000		10				21
22	Carpeting 12 Il units 6 AL units 2 Skilled units 1 repair			2011	30,356		5				22
23	Landscapting			2011	135		5				23
24	Dyrwall and painting - remodeled marketing area			2011	1,800		5				24
25	Marketing Area Enclosure			2011	3,911		5				25
26	Remove and repair sidewalks			2011	2,600		20				26
27	Vinyl Independent living units			2012	681		5				27
28	Creative Carpet			2010	9,610		5				28
29	Carpeting			2012	42,476		5				29
30	Thermocore Door			2012	4,016		10				30
31	Sprinkler Repair			2012	6,057		5				31
32	Fountain Winterizing			2012	300		5				32
33	SC Phase 2A			2012	194,994		15				33
34	SC Phase 2C			2012	358,943		15				34
35	Spring Fountain Install/Sprinkler Repair			2012	3,850		5				35
36	Sprinkler Repair			2012	844		5				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: 07/01/2014 Ending: 06/30/2015

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	SC Phase 2B	2013	$ 27,750,890	$	15	$	$	$	37
38	SC Phase 2	2013	276,916		15				38
39	Courtyard Lighting	2014	5,265		15				39
40	Construction Adjustment	2014	8,957		15				40
41	IT Suite	2014	285,631		15				41
42	Salon/Spa	2015	16,407		5				42
43	New Entrance Door	2015	12,956		5				43
44	Concrete Pier	2015	6,945		5				44
45	Four Season Room	2015	10,000		10				45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55	Total Building & Building Improvements Depreciation Expense			3,014,086		3,014,086		15,600,265	55
56	Less: AL/IL Depreciation			(2,570,243)		(2,570,243)			56
57	Add: Home Office Allocation			43,070		43,070			57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 75,666,455	$ 486,913		$ 486,913	$	$ 15,600,265	70

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,349,429	$ 55,211	$ 55,211	$	Various	$ 942,888	71
72	Current Year Purchases	186,519	8,429	8,429		Various	8,429	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,535,948	$ 63,640	$ 63,640	$		$ 951,317	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	33,695	79
80	TOTALS			$ 166,788	$ 6,739	$ 6,739	$		$ 128,600	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)	$ 84,821,830	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 557,292	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 557,292	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 16,680,182	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		$	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.

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: 07/01/2014 Ending: 06/30/2015

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.

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	10-3a	hrs	$	3,944	$ 204,774	$	3,944	$ 204,774	1
2	Licensed Speech and Language Development Therapist	10-3a	hrs		611	37,553		611	37,553	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-3a	hrs		4,377	413,745		4,377	413,745	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			$	8,932	$ 656,072	$	8,932	$ 656,072	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: 07/01/2014 Ending: 06/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2015 (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	$ 2,772,574	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 93,714)	1,785,779		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,694		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)**	$ 4,649,047	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,928,426		12
13	Land	6,452,639		13
14	Buildings, at Historical Cost	75,666,454		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,702,736		16
17	Accumulated Depreciation (book methods)	(16,680,182)		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**	1,808,014		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 77,878,087	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 82,527,134	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,444,677	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	354,141		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	760,221		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,559,039	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	36,979,057		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule	46,261,675		43
44	Interest Rate Swap Agreement	1,734,328		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 84,975,060	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 88,534,099	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (6,006,965)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 82,527,134	$	48

*(See instructions.)

Facility Name & ID Number Smith Crossing **#** 0046698 **Report Period Beginning:** 07/01/2014 **Ending:** 06/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,514,924)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,514,924)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,016,488)	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) **Correction of Prior Year Error**	(1,475,556)	15	
16	Other (describe) **Rounding**	3	16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,492,041)	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)**	$ (6,006,965)	24	*

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

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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	$ 15,707,887	1
2	Discounts and Allowances for all Levels	(1,480,852)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,227,035	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,251,275	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,251,275	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	103,370	13
14	Non-Patient Meals	121,930	14
15	Telephone, Television and Radio	1,828	15
16	Rental of Facility Space	13,084	16
17	Sale of Drugs	295,168	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	69,981	19
20	Radiology and X-Ray	22,056	20
21	Other Medical Services	232,138	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 859,555	23
	D. Non-Operating Revenue		
24	Contributions	60,192	24
25	Interest and Other Investment Income***	(390,874)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (330,682)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	26,714	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 26,714	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,033,897	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	4,294,844	31
32	Health Care	3,605,885	32
33	General Administration	3,051,008	33
	B. Capital Expense		
34	Ownership	4,548,772	34
	C. Ancillary Expense		
35	Special Cost Centers	1,524,691	35
36	Provider Participation Fee	25,185	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,050,385	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,016,488)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,016,488)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 173,451	44
45	Private Pay - Net Inpatient Revenue	12,508,966	45
46	Medicare - Net Inpatient Revenue	1,542,484	46
47	Other-(specify) Hospice	2,134	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,227,035	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.**

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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	1,800	1,988	$ 89,156	$ 44.85	1
2	Assistant Director of Nursing	1,823	1,950	65,471	33.57	2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	38,027	41,304	496,424	12.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,495	3,975	73,948	18.60	9
10	Activity Assistants	11,855	13,383	179,541	13.42	10
11	Social Service Workers	1,914	2,203	64,527	29.29	11
12	Dietician					12
13	Food Service Supervisor	1,712	1,985	26,368	13.28	13
14	Head Cook	3,712	4,055	60,204	14.85	14
15	Cook Helpers/Assistants	70,208	74,203	795,757	10.72	15
16	Dishwashers					16
17	Maintenance Workers	11,084	12,280	204,680	16.67	17
18	Housekeepers	31,239	31,583	347,987	11.02	18
19	Laundry	5,079	5,886	61,286	10.41	19
20	Administrator	1,785	1,988	133,505	67.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,434	11,037	142,382	12.90	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	617	635	9,170	14.44	31
32	Other Health C: Marketing	5,264	5,941	190,965	32.14	32
33	Other(specify) AL	32,766	35,430	449,606	12.69	33
34	TOTAL (lines 1 - 33)	232,814	249,826	$ 3,390,977 *	$ 13.57	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	2,420	100,292	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	AL Nursing	11,132	352,982	10-3	47
48					48
49	TOTAL (lines 35 - 48)	13,552	$ 453,274		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	23,778	$ 811,572	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	23,778	$ 811,572		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Frank Guajardo	Executive Director	0	$ 133,505
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 133,505

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Polsinelli Shughart PC	Legal	$ 6,442
CliftonLarsonAllen	Audit	23,250
Paylocity	Payroll Services	12,998
Consulting	Consulting	3,045
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 45,735

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 112,510
Unemployment Compensation Insurance	
FICA Taxes	245,304
Employee Health Insurance	353,124
Employee Meals	47,879
Illinois Municipal Retirement Fund (IMRF)*	
Disability insurance	3,003
Life insurance	1,912
Pension / 401K	15,337
PTO Used / Not Paid	10,538
Tuition	6,237
Less: Non-allowed AL/IL employee benefits	(92,770)
Add: Home Office employee benefits	279,277
TOTAL (agree to Schedule V, line 22, col.8)	$ 982,351

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

Description	Line #	Amount
		$
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	3,190
(Indicate # of checks performed 64)	
Patient Background Checks 319	2,240
Dues & Memberships	6,277
Subscriptions	3,437
Association Dues	12,360
Employee Recruitment	12,029
Less: Non-allowed AL/IL costs	(1,250)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,283

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,546
Seminar Expense	8,789
Less: Non-allowed AL/IL expenses	0
Add: Home Office allocation	22,296
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,631

**See instructions.

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2014 Ending: 06/30/2015

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													
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9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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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. **Leading Age $9,024**

(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. $ **28,243** 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. $ **25,185**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **47,879** 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) 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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.