		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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[X] VOLUNTARY,NON-PROFIT	[ ] PROPRIETARY	[ ] GOVERNMENTAL
[X] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code ______	[ ] 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 07/01/2019 to 06/30/2020 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)	CFO
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Deborah Emerson, 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: 07/01/2019 Ending: 06/30/2020

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	46	Skilled (SNF)	46	16,836	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	16,836	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	326	10,942	3,860	15,128	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	326	10,942	3,860	15,128	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.86%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [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 3,277

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

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

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

Tax Year: 06/30/2020 Fiscal Year: 06/30/2020

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	1,099,514	116,087	576,773	1,792,374		1,792,374	(1,370,705)	421,669			1
2	Food Purchase		976,147		976,147		976,147	(849,886)	126,261			2
3	Housekeeping	503,948	63,584	138	567,670		567,670	(360,349)	207,321			3
4	Laundry	64,570	27,891	40	92,501		92,501	(56,481)	36,020			4
5	Heat and Other Utilities			579,294	579,294		579,294	(353,718)	225,576			5
6	Maintenance	406,956	33,322	1,191,650	1,631,928		1,631,928	(996,915)	635,013			6
7	Other (specify):*											7
8	**TOTAL General Services**	2,074,988	1,217,031	2,347,895	5,639,914		5,639,914	(3,988,054)	1,651,860			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,467,032	66,912	1,965,809	3,499,753		3,499,753	(1,061,327)	2,438,426			10
10a	Therapy		401	642,793	643,194		643,194		643,194			10a
11	Activities	275,045	11,161	118,561	404,767		404,767	(252,810)	151,957			11
12	Social Services	74,345	133	1,602	76,080		76,080	(46,455)	29,625			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,816,422	78,607	2,743,765	4,638,794		4,638,794	(1,360,591)	3,278,203			16
	C. General Administration											
17	Administrative					177,607	177,607		177,607			17
18	Directors Fees											18
19	Professional Services			65,813	65,813		65,813	23,824	89,637			19
20	Dues, Fees, Subscriptions & Promotions			94,418	94,418		94,418	(1,985)	92,433			20
21	Clerical & General Office Expenses	375,326	124,806	1,947,679	2,447,811	(177,607)	2,270,204	(1,523,740)	746,464			21
22	Employee Benefits & Payroll Taxes			1,045,650	1,045,650		1,045,650	283,267	1,328,917			22
23	Inservice Training & Education			31,139	31,139		31,139		31,139			23
24	Travel and Seminar			8,589	8,589		8,589	17,935	26,524			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			395,984	395,984		395,984	(214,460)	181,524			26
27	Other (specify):*											27
28	**TOTAL General Administration**	375,326	124,806	3,589,272	4,089,404		4,089,404	(1,415,159)	2,674,245			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,266,736	1,420,444	8,680,932	14,368,112		14,368,112	(6,763,805)	7,604,307			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: 07/01/2019 Ending: 06/30/2020

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			3,427,245	3,427,245		3,427,245	(2,075,667)	1,351,578			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,291,302	1,291,302		1,291,302	(318,753)	972,549			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			52,864	52,864		52,864	(32,279)	20,585			35
36	Other (specify):*											36
37	TOTAL Ownership			4,771,411	4,771,411		4,771,411	(2,426,699)	2,344,712			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116	344,229	344,345		344,345		344,345			39
40	Barber and Beauty Shops	45,659	6,094	78,900	130,653		130,653		130,653			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,254	25,254		25,254		25,254			42
43	Other (specify):* Marketing	170,478	621	498,295	669,394		669,394	(669,394)				43
44	TOTAL Special Cost Centers	216,137	6,831	946,678	1,169,646		1,169,646	(669,394)	500,252			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,482,873	1,427,275	14,399,021	20,309,169		20,309,169	(9,859,897)	10,449,272			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 7/1/2019** **Ending: 6/30/2020**

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule		**To Line**	**From Line**
Reclassify administrator wages	$ 177,607	17	21

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	(105,834)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(13,728)	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	(769,272)	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)	(202)	6		16
17	Non-Care Related Fees	(5,658)	11		17
18	Fines and Penalties	(268)	21		18
19	Entertainment	(1,437)	24		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	19,833	21		24
25	Fund Raising, Advertising and Promotional	(669,394)	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	(8,410,453)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,956,413)		$	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)	100,889		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 100,889		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (9,855,524)		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

Smith Crossing

ID# 0046698

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AL/IL dietary costs	$ (1,370,705)	1	1
2	AL/IL food purchases	(746,501)	2	2
3	AL/IL housekeeping	(346,621)	3	3
4	AL/IL laundry	(56,481)	4	4
5	AL/IL heat & other utilities	(353,718)	5	5
6	AL/IL maintenance	(996,459)	6	6
7	AL/IL nursing costs	(1,061,327)	10	7
8	AL/IL activities	(247,152)	11	8
9	AL/IL Social Services	(46,455)	12	9
10	AL/IL Dues, fees, subs	(1,985)	20	10
11	AL/IL office & clerical	(25,947)	21	11
12	Miscellaneous income	(330,023)	21	12
13	Medication Setup income	(28,613)	21	13
14	AL/IL nursing & admissions emp benefits	(112,708)	22	14
15	AL/IL insurance	(241,789)	26	15
16	AL/IL depreciation	(2,092,684)	30	16
17	AL/IL bond interest	(318,753)	32	17
18	AL/IL equipment rent	(32,279)	35	18
19	Maintenance late Fees	(254)	6	19
20	Non-Allowable Travel/Seminar	(4,373)	24	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,414,826)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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

	Operating Expenses A. General Services	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)	
1	Dietary	(1,370,705)	0	0	0	0	0	0	0	0	0	0	(1,370,705)	1
2	Food Purchase	(852,335)	2,449	0	0	0	0	0	0	0	0	0	(849,886)	2
3	Housekeeping	(360,349)	0	0	0	0	0	0	0	0	0	0	(360,349)	3
4	Laundry	(56,481)	0	0	0	0	0	0	0	0	0	0	(56,481)	4
5	Heat and Other Utilities	(353,718)	0	0	0	0	0	0	0	0	0	0	(353,718)	5
6	Maintenance	(996,915)	0	0	0	0	0	0	0	0	0	0	(996,915)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,990,503)	2,449	0	0	0	0	0	0	0	0	0	(3,988,054)	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	(1,061,327)	0	0	0	0	0	0	0	0	0	0	(1,061,327)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(252,810)	0	0	0	0	0	0	0	0	0	0	(252,810)	11
12	Social Services	(46,455)	0	0	0	0	0	0	0	0	0	0	(46,455)	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**	(1,360,591)	0	0	0	0	0	0	0	0	0	0	(1,360,591)	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	23,824	0	0	0	0	0	0	0	0	0	23,824	19
20	Fees, Subscriptions & Promotions	(1,985)	0	0	0	0	0	0	0	0	0	0	(1,985)	20
21	Clerical & General Office Expenses	(1,134,290)	(389,450)	0	0	0	0	0	0	0	0	0	(1,523,740)	21
22	Employee Benefits & Payroll Taxes	(112,708)	395,975	0	0	0	0	0	0	0	0	0	283,267	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,810)	23,745	0	0	0	0	0	0	0	0	0	17,935	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(241,789)	27,329	0	0	0	0	0	0	0	0	0	(214,460)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,496,582)	81,423	0	0	0	0	0	0	0	0	0	(1,415,159)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,847,677)	83,872	0	0	0	0	0	0	0	0	0	(6,763,805)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	(2,092,684)	17,017	0	0	0	0	0	0	0	0	0	(2,075,667)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(318,753)	0	0	0	0	0	0	0	0	0	0	(318,753)	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	(32,279)	0	0	0	0	0	0	0	0	0	0	(32,279)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,443,716)	17,017	0	0	0	0	0	0	0	0	0	(2,426,699)	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(669,394)	0	0	0	0	0	0	0	0	0	0	(669,394)	43
44	**TOTAL Special Cost Centers**	(669,394)	0	0	0	0	0	0	0	0	0	0	(669,394)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(9,960,786)	100,889	0	0	0	0	0	0	0	0	0	(9,859,897)	45

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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		$ 2,449	$ 2,449	1
2	V	19	Professional Serivces		Smith Senior Living		23,824	23,824	2
3	V	21	Clerical & General Office Exp		Smith Senior Living		1,327,362	1,327,362	3
4	V	22	PR Taxes & Employee Benefits		Smith Senior Living		395,975	395,975	4
5	V	24	Travel and Seminar		Smith Senior Living		23,745	23,745	5
6	V	26	Insurance		Smith Senior Living		27,329	27,329	6
7	V	30	Depreciation		Smith Senior Living		17,017	17,017	7
8	V								8
9	V								9
10	V								10
11	V	21	Management Fees	1,716,812				(1,716,812)	11
12	V								12
13	V								13
14	Total			$ 1,716,812			$ 1,817,701	$ * 100,889	14

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	Andrew J. Anello	BOD						1
2	John E. Leahy	BOD						2
3	Kevin A. Lane	BOD						3
4	Judith K. Lewis	BOD						4
5	George E. Petraitis	BOD						5
6	Timothy Regan	BOD						6
7	Kay E. Thurn	BOD						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: 07/01/2019 Ending: 06/30/2020

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Andrew J. Anello	Chair							$		1
2	John E. Leahy	Vice Chair									2
3	Kevin A. Lane	Trustee									3
4	Judith K. Lewis	Trustee									4
5	George E. Petraitis	Trustee									5
6	Timothy Regan	Trustee									6
7	Kay E. Thurn	Ex-Officio									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: 07/01/2019 Ending: 6/30/2020

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

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

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

	1 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	42,495,779	2	$ 5,125	$	20,302,784	$ 2,449	1
2	19	Professional Serivces	Direct Costs	42,495,779	2	49,865		20,302,784	23,824	2
3	21	Clerical & General Office Exp	Direct Costs	42,495,779	2	2,778,303		20,302,784	1,327,362	3
4	22	PR Taxes & Employee Benefits	Direct Costs	42,495,779	2	828,815		20,302,784	395,975	4
5	24	Travel and Seminar	Direct Costs	42,495,779	2	49,701		20,302,784	23,745	5
6	26	Insurance	Direct Costs	42,495,779	2	57,203		20,302,784	27,329	6
7	30	Depreciation	Direct Costs	42,495,779	2	35,619		20,302,784	17,017	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					$ 3,804,631	$		$ 1,817,701	25

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	Series 2018A Bond		X	Refinance	N/A	10/10/18	$ 24,500,000	$ 21,250,086	10/1/2043	Variable	$	1
2	Series 2018B Bond		X	Refinance	N/A	10/10/18	18,064,000	17,433,000	10/1/2043	Variable	695,893	2
3	Series 2018C Bond		X	Refinance	N/A	10/10/18	14,686,000	14,173,000	10/1/2043	Variable	557,700	3
4												4
5												5
	Working Capital											
6	Proven Business Systems		X	Copier Lease	$410.00	6/11/14	21,561				14	6
7												7
8												8
9	TOTAL Facility Related				$410.00		$ 57,271,561	$ 52,856,086			$ 1,253,607	9
	B. Non-Facility Related*											
10												10
11												11
12	Debt Issuance Costs										37,695	12
13	AL/IL Bond Interest										(318,753)	13
14	TOTAL Non-Facility Related						$	$			$ (281,058)	14
15	TOTALS (line 9+line14)						$ 57,271,561	$ 52,856,086			$ 972,549	15

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

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

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2019 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 2020 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:			Line
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 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

TELEPHONE 773-474-7350 FAX #: 773-474-7357

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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: 07/01/2019 Ending: 06/30/2020

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 - 276,788 square feet - 97 units
Smith Crossing, Assisted Living - 50,432 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		1,306,800	2001	$ 6,452,639	1
2					2
3	TOTALS	1,306,800		$ 6,452,639	3

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	Various			2008	27,212		10				12
13	Various			2009	85,261		10				13
14	Various			2010	40,467		10				14
15	Various			2011	58,802		10				15
16	Various			2012	553,868		10				16
17	Various			2013	28,027,806		15				17
18	Courtyard Lighting			2014	5,265		15				18
19	Construction Adjustment			2014	8,957		15				19
20	IT Suite			2014	285,631		15				20
21	Salon/Spa			2015	16,407		5				21
22	New Entrance Door			2015	12,956		5				22
23	Concrete Pier			2015	6,945		5				23
24	Deposit for addition of four seasons room to Villa 10408			2015	10,000		10				24
25	Remaining payment for four seasons room addition to Villa 10408			2015	15,286		10				25
26	Repairs to Asphalt			2015	8,923		5				26
27	Villa 10410 Window Upgrades			2015	7,012		10				27
28	Villa Driveway Repairs			2016	42,265		10				28
29	Swing gate/Black Handrails w/posts			2015	3,550		10				29
30	Walk-in Freezer and ramp			2015	21,403		10				30
31	Apt 2307 Upgrades - custom cabinets, carpeting, painting			2015	20,504		10				31
32	Windown tinting - AL Corridor/Dining Room			2015	5,800		10				32
33	Drain tile system repairs			2016	3,100		10				33
34	Garage Doors - Villas 10430-10432			2016	4,590		10				34
35	Security System			2016	11,610		5				35
36				2016	37,201						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: 07/01/2019 Ending: 06/30/2020

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Roof Access Repairs	2016	$ 10,575	$	5	$	$	$	37
38	Unit 1203 IL Upgrades, carpeting and hardwood floors	2016	10,243		10				38
39	Heating Updates, AL dining, common and laundry areas	2016	42,439		10				39
40	Unit 1307 IL Upgrades, custom cabinets	2016	12,383		10				40
41	Dietary Panels	2016	5,402		10				41
42	Unit 2118 IL Upgrades, custom cabinets	2016	13,367		10				42
43	Unit Upgrades, custom cabinets, painting, carpeting and hardwoo	2016	212,019		10				43
44	Wall Safes	2016	21,625		10				44
45	Telephone System	2016	102,915		10				45
46	Heating Unit #7	2017	15,710		10				46
47	Conference room #2205, 1104 upgrades; base, shoe, desks, cabinet	2018	5,045		5				47
48	Skilled Spa Upgrades; demo old vanity tops, install cleats, drywall,								48
49	tile, spa floor	2018	30,277		10				49
50	Skilled Common area upgrades; tables, chairs, renovation	2018	22,448		5				50
51	Heating/Air System - Skilled	2018	6,284		15				51
52	Replace Heating Unit - SNF	2019	6,284		20				52
53	Replace Heating Unit - TCU	2019	6,284		20				53
54									54
55									55
56	Less AL/IL, non-care fixed assets		(46,549,752)						56
57									57
58	Total Building & Building Improvements Depreciation Expense			3,201,046		3,201,046		30,064,944	58
59	Less: AL/IL Depreciation			(1,954,559)		(1,954,559)		(18,357,655)	59
60	Add: Home Office Allocation			17,017		17,017			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)		$ 29,762,953	$ 1,263,504		$ 1,263,504	$	$ 11,707,289	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: 07/01/2019 Ending: 06/30/2020

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	$ 2,630,968	$ 222,598	$ 222,598	$		$ 1,372,357	71
72	Current Year Purchases	148,463						72
73	Fully Depreciated Assets							73
74		(90,652)	(138,124)	(138,124)			(837,961)	74
75	TOTALS	$ 2,688,779	$ 84,474	$ 84,474	$		$ 534,396	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attached			$ 202,788	$ 3,600	$ 3,600	$	10	$ 175,638	76
77										77
78										78
79										79
80	TOTALS			$ 202,788	$ 3,600	$ 3,600	$		$ 175,638	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)	$ 39,107,159	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,351,578	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,351,578	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)	$ 12,417,323	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	AL/IL, Building, Equipment	$ 46,640,404	$ 2,092,683	$ 19,195,616	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 46,640,404	$ 2,092,683	$ 19,195,616	91

G. Construction-in-Progress

	Description	Cost	
92	CIP - Phase 3	$ 20,754,289	92
93			93
94			94
95		$ 20,754,289	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: 07/01/2019 Ending: 06/30/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 52,864 Description: O2 Tank Rentals - $38,727, Dining Equip - $8,150, Dining Furniture - $130, Surgical Supply Rental - $5,857
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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 ____

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3,2	hrs	$	3,911	$ 212,565	$ 401	3,911	$ 212,966	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,370	88,282		1,370	88,282	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3, 39-2	hrs		5,883	341,946	116	5,883	342,062	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				211,233		211,233	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Billable Supplies	39-3					84,692		84,692	12
13	Other (specify): X-Ray/Lab/Other	39-3					48,304		48,304	13
14	TOTAL			$	11,164	$ 642,793	$ 344,746	11,164	$ 987,539	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Smith Crossing** # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2020 (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	$ 4,183,021	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,353)	2,510,432		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,176		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)**	$ 6,761,629	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,151,821		12
13	Land	6,452,639		13
14	Buildings, at Historical Cost	80,486,847		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,461,285		16
17	Accumulated Depreciation (book methods)	(31,612,939)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	20,754,289		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 95,693,942	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 102,455,571	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,715,984	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	319,603		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	67,777		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,208,518		36
37	Current Portion of LT Debt	1,628,100		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,939,982	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	921,100		39
40	Mortgage Payable			40
41	Bonds Payable	50,841,610		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	50,615,104		43
44	Interest Rate Swap	11,099,869		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 113,477,683	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 119,417,665	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (16,962,094)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 102,455,571	$	48

*(See instructions.)

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (10,682,830)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (10,682,830)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,279,266)	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) Rounding	2	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (6,279,264)	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)**	$ (16,962,094)	24 *

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

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	$ 18,485,691	1
2	Discounts and Allowances for all Levels	(1,462,155)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 17,023,536	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,246,800	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,246,800	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	113,024	13
14	Non-Patient Meals	105,834	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	13,728	16
17	Sale of Drugs	204,279	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,106	19
20	Radiology and X-Ray	11,562	20
21	Other Medical Services	168,549	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 655,082	23
	D. Non-Operating Revenue		
24	Contributions	8,349	24
25	Interest and Other Investment Income***	128,053	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 136,402	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached Schedule	364,496	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 364,496	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 19,426,316	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,639,914	31
32	Health Care	4,638,794	32
33	General Administration	4,089,404	33
	B. Capital Expense		
34	Ownership	4,771,411	34
	C. Ancillary Expense		
35	Special Cost Centers	1,144,392	35
36	Provider Participation Fee	25,254	36
	D. Other Expenses (specify):		
37	Change in Fair Value of Swap	5,396,413	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 25,705,582	40
41	**Income before Income Taxes (line 30 minus line 40)****	(6,279,266)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (6,279,266)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 41,931	44
45	Private Pay - Net Inpatient Revenue	16,057,216	45
46	Medicare - Net Inpatient Revenue	907,137	46
47	Other-(specify) Hospice/Insurance	17,252	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 17,023,536	49

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

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

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

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,829	2,259	$ 124,012	$ 54.90	1
2	Assistant Director of Nursing	2,149	3,022	114,758	37.97	2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	36,807	39,419	666,540	16.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,990	2,233	44,665	20.00	9
10	Activity Assistants	12,686	13,904	230,380	16.57	10
11	Social Service Workers	1,770	1,998	74,345	37.21	11
12	Dietician					12
13	Food Service Supervisor	3,660	4,048	64,279	15.88	13
14	Head Cook	12,772	14,483	232,866	16.08	14
15	Cook Helpers/Assistants	44,914	46,415	650,716	14.02	15
16	Dishwashers	10,410	11,223	151,653	13.51	16
17	Maintenance Workers	17,116	18,897	406,955	21.53	17
18	Housekeepers	31,783	34,514	503,949	14.60	18
19	Laundry	4,653	4,940	64,570	13.07	19
20	Administrator	2,529	2,630	177,607	67.54	20
21	Assistant Administrator					21
22	Other Administrative	926	1,058	25,947	24.52	22
23	Office Manager					23
24	Clerical	9,754	9,982	171,772	17.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,785	1,768	36,845	20.84	31
32	Other Health C: Marketing	4,834	5,566	170,477	30.63	32
33	Other(specify) AL/Salon	31,625	34,375	570,537	16.60	33
34	TOTAL (lines 1 - 33)	233,991	252,736	$ 4,482,873 *	$ 17.74	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$ 575,876	01-3	35
36	Medical Director				36
37	Medical Records Consultant		15,000	09-3	37
38	Nurse Consultant		1,200	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		1,788	11-3	44
45	Social Service Consultant		1,602	12-3	45
46	Other(specify) Marketing Consultant		162,853	43-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 758,319		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	20,516	$ 886,197	10-3	50
51	Licensed Practical Nurses	13,989	582,737	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	34,505	$ 1,468,934		53

Facility Name & ID Number: Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Frank Guajardo	Executive Director		$ 177,607
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 177,607

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
UST		$ 12,926
Lee Moriarty		683
The Arbitrage Group	Rebate Reports	750
CLA	Accounting/Consulting	21,150
Polsinelli Shughart	Legal	2,171
Hinshaw & Culbertson LLP	Legal	3,750
Quarles & Brady, LLC	Legal	240
Paylocity	Payroll Services	24,143
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 65,813

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 178,901
Unemployment Compensation Insurance	
FICA Taxes	316,791
Employee Health Insurance	404,323
Employee Meals	41,649
Illinois Municipal Retirement Fund (IMRF)*	
Disability insurance	2,696
Life insurance	1,517
Pension / 401K	55,961
PTO Used / Not Paid	40,512
Tuition	3,300
Less: Non-allowed AL/IL employee benefits	(112,708)
Add: Home Office employee benefits	395,975
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,328,917

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	54,341
Health Care Worker Background Check (Indicate # of checks performed 86)	1,492
Patient Background Checks 7	70
Dues & Memberships	14,440
Subscriptions	6,438
Association Dues	17,637
Less: Non-allowed AL/IL costs	(1,985)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 92,433

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,085
Seminar Expense	6,067
Add: Home Office Allocation	23,745
Less: non-allowable	(4,373)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 26,524

**See instructions.

Invoice Date	Firm Name	Allowable Amt	Non-Allow Amt	Description of Services
7/31/2019	POLSINELLI SHUGHART	1,788.00		Resident contracts, physician assessments
7/31/2019	POLSINELLI SHUGHART	120.00		Call regarding priest
7/31/2019	POLSINELLI SHUGHART	62.00		Emails re: open ites
8/31/2019	POLSINELLI SHUGHART	201.00		Review voluntary transfer and correpondence
10/31/2019	HINSHAW & CULBERTSON LLP	3,750.00		SNF contract edits and regulations
1/31/2020	QUARLES & BRADY, LLC	240.00		Title matters re: Mortgage
		6,161.00		

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 - $17,925**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,647** 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. $ **25,254**
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. $ **41,649** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **105,834**

(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? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **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 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.