

Facility Name & ID Number Smith Crossing

0046698 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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	30	Skilled (SNF)	30	10,950	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	30	TOTALS	30	10,950	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	808	5,895	1,699	8,402	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	808	5,895	1,699	8,402	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.73%

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

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

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

N/A

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

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

YES NO

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

YES NO

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

Date started 10/18/2005

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

YES Date 11/01/2003 NO

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

YES NO If YES, enter number of beds certified 30 and days of care provided 1,699

Medicare Intermediary National Government Services (NGS)

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/2009 Fiscal Year: 06/30/2009

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2008 Ending: 06/30/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	626,433	73,659	326,530	1,026,622		1,026,622	(833,967)	192,655		1
2	Food Purchase		534,490		534,490		534,490	(434,188)	100,302		2
3	Housekeeping	163,726	19,450		183,176		183,176	(152,036)	31,140		3
4	Laundry	22,750	8,484		31,234		31,234	(12,493)	18,741		4
5	Heat and Other Utilities			181,323	181,323		181,323	(150,498)	30,825		5
6	Maintenance	276,000	24,524	234,817	535,341		535,341	(444,348)	90,993		6
7	Other (specify):*										7
8	TOTAL General Services	1,088,909	660,607	742,670	2,492,186		2,492,186	(2,027,530)	464,656		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,013,432	30,010	399,006	1,442,448		1,442,448	(506,423)	936,025		10
10a	Therapy			148,000	148,000		148,000		148,000		10a
11	Activities	222,108	27,887	123,166	373,161		373,161	(137,719)	235,442		11
12	Social Services	55,703	123	501	56,327		56,327		56,327		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,291,243	58,020	682,673	2,031,936		2,031,936	(644,142)	1,387,794		16
	C. General Administration										
17	Administrative	232,857		709,305	942,162	(120,600)	821,562	(709,305)	112,257		17
18	Directors Fees										18
19	Professional Services			63,684	63,684		63,684	22,507	86,191		19
20	Dues, Fees, Subscriptions & Promotions			97,183	97,183		97,183	(70,530)	26,653		20
21	Clerical & General Office Expenses		4,398	70,481	74,879	120,600	195,479	368,445	563,924		21
22	Employee Benefits & Payroll Taxes			805,078	805,078		805,078	(361,248)	443,830		22
23	Inservice Training & Education			4,429	4,429		4,429	(2,312)	2,117		23
24	Travel and Seminar			11,508	11,508		11,508	702	12,210		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			77,109	77,109		77,109	(54,400)	22,709		26
27	Other (specify):*			3,591	3,591		3,591	(3,591)			27
28	TOTAL General Administration	232,857	4,398	1,842,368	2,079,623		2,079,623	(809,732)	1,269,891		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,613,009	723,025	3,267,711	6,603,745		6,603,745	(3,481,404)	3,122,341		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:

07/01/2008

Ending:

06/30/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			1,162,507	1,162,507		1,162,507	(931,915)	230,592			30
31	Amortization of Pre-Op. & Org.			199,170	199,170		199,170	(165,311)	33,859			31
32	Interest			1,544,247	1,544,247		1,544,247	(1,282,085)	262,162			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,905,924	2,905,924		2,905,924	(2,379,311)	526,613			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		127,484	8,986	136,470		136,470		136,470			39
40	Barber and Beauty Shops			27,684	27,684		27,684	(27,684)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			16,630	16,630		16,630		16,630			42
43	Other (specify):*	60,705	989	136,696	198,390		198,390	(198,391)	(1)			43
44	TOTAL Special Cost Centers	60,705	128,473	189,996	379,174		379,174	(226,075)	153,099			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,673,714	851,498	6,363,631	9,888,843		9,888,843	(6,086,790)	3,802,053			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(21,717)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	2	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(168)	27		24
25	Fund Raising, Advertising and Promotional				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,883)		\$	30

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

		1	2	
		Amount	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)	(46,078)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (46,078)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (67,961)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	IL/AL Dietary Costs	\$ (833,967)	1	1
2	IL/AL Food Purchases	(434,188)	2	2
3	IL/AL Housekeeping Costs	(152,036)	3	3
4	IL/AL Laundry	(12,493)	4	4
5	IL/AL Heating & Other Utilities	(150,498)	5	5
6	IL/AL Maintenance Costs	(432,109)	6	6
7	EVS Late Fees	(91)	6	7
8	Cable TV	(12,148)	6	8
9	AL/MS Nursing Wages	(506,423)	10	9
10	AL/MS Activities Wages	(55,135)	11	10
11	AL/MS Activities Supplies / Other	(82,584)	11	11
12	Flowers	0	15	12
13	AL/IL Administrative	0	17	13
14	Professional Services	(48,599)	19	14
15	AL/IL Dues, Fees, Subscriptions	(74,163)	20	15
16	AL/IL Clerical & General Office	(132,602)	21	16
17	AL/IL Employee Benefits	(468,378)	22	17
18	AL/IL Inservice	(3,582)	23	18
19	AL/IL Travel & Seminars	(6,214)	24	19
20	AL/IL Insurance	(64,000)	26	20
21	Admin Late Fees	(129)	27	21
22	Investment Advisory Fees	(3,294)	27	22
23	AL/IL Depreciation	(964,881)	30	23
24	AL/IL Bond Interest Expense	(1,282,085)	32	24
25	AL/IL Other Interest Expense	0	32	25
26	Barber / Beauty Shop Revenue Offset	(27,684)	40	26
27	Marketing Wages	(60,705)	43	27
28	Marketing Supplies & Other	(137,686)	43	28
29	Amortization	(165,311)	31	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,110,985)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Crossing# 0046698

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(833,967)	0	0	0	0	0	0	0	0	0	0	(833,967)	1
2	Food Purchase	(434,188)	0	0	0	0	0	0	0	0	0	0	(434,188)	2
3	Housekeeping	(152,036)	0	0	0	0	0	0	0	0	0	0	(152,036)	3
4	Laundry	(12,493)	0	0	0	0	0	0	0	0	0	0	(12,493)	4
5	Heat and Other Utilities	(150,498)	0	0	0	0	0	0	0	0	0	0	(150,498)	5
6	Maintenance	(444,348)	0	0	0	0	0	0	0	0	0	0	(444,348)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,027,530)	0	0	0	0	0	0	0	0	0	0	(2,027,530)	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	(506,423)	0	0	0	0	0	0	0	0	0	0	(506,423)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(137,719)	0	0	0	0	0	0	0	0	0	0	(137,719)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(644,142)	0	0	0	0	0	0	0	0	0	0	(644,142)	16
	C. General Administration													
17	Administrative	0	(709,305)	0	0	0	0	0	0	0	0	0	(709,305)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(48,599)	71,106	0	0	0	0	0	0	0	0	0	22,507	19
20	Fees, Subscriptions & Promotions	(74,163)	3,633	0	0	0	0	0	0	0	0	0	(70,530)	20
21	Clerical & General Office Expenses	(154,317)	522,762	0	0	0	0	0	0	0	0	0	368,445	21
22	Employee Benefits & Payroll Taxes	(468,378)	107,130	0	0	0	0	0	0	0	0	0	(361,248)	22
23	Inservice Training & Education	(3,582)	1,270	0	0	0	0	0	0	0	0	0	(2,312)	23
24	Travel and Seminar	(6,214)	6,916	0	0	0	0	0	0	0	0	0	702	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(64,000)	9,600	0	0	0	0	0	0	0	0	0	(54,400)	26
27	Other (specify):*	(3,591)	0	0	0	0	0	0	0	0	0	0	(3,591)	27
28	TOTAL General Administration	(822,844)	13,112	0	(809,732)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,494,516)	13,112	0	(3,481,404)	29								

STATE OF ILLINOIS

Facility Name & ID Number Smith Crossing# 0046698

Report Period Beginning:

07/01/2008 Ending:

Summary B

06/30/2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(964,881)	32,966	0	0	0	0	0	0	0	0	0	(931,915)	30
31	Amortization of Pre-Op. & Org.	(165,311)	0	0	0	0	0	0	0	0	0	0	(165,311)	31
32	Interest	(1,282,085)	0	0	0	0	0	0	0	0	0	0	(1,282,085)	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	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,412,277)	32,966	0	(2,379,311)	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	(27,684)	0	0	0	0	0	0	0	0	0	0	(27,684)	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):*	(198,391)	0	0	0	0	0	0	0	0	0	0	(198,391)	43
44	TOTAL Special Cost Centers	(226,075)	0	0	0	0	0	0	0	0	0	0	(226,075)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(6,132,868)	46,078	0	0	0	0	0	0	0	0	0	(6,086,790)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		<u>Smith Village</u>	<u>Chicago IL</u>	<u>Smith Senior Living</u>	<u>Chicago, IL</u>	<u>Not-for-Profit</u>

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	<u>19 Professional Services</u>	\$	<u>Smith Senior Living - Home Office</u>		\$ <u>71,106</u>	\$	<u>71,106</u>	1
2	V	<u>20 Fees, Subscriptions & Promo</u>		<u>Smith Senior Living - Home Office</u>		<u>3,633</u>		<u>3,633</u>	2
3	V	<u>21 Clerical & General Office</u>		<u>Smith Senior Living - Home Office</u>		<u>522,762</u>		<u>522,762</u>	3
4	V	<u>22 Employee Benefits</u>		<u>Smith Senior Living - Home Office</u>		<u>107,130</u>		<u>107,130</u>	4
5	V	<u>23 Inservice Training & Education</u>		<u>Smith Senior Living - Home Office</u>		<u>1,270</u>		<u>1,270</u>	5
6	V	<u>24 Travel & Seminars</u>		<u>Smith Senior Living - Home Office</u>		<u>6,916</u>		<u>6,916</u>	6
7	V	<u>26 Insurance</u>		<u>Smith Senior Living - Home Office</u>		<u>9,600</u>		<u>9,600</u>	7
8	V	<u>30 Depreciation</u>		<u>Smith Senior Living - Home Office</u>		<u>32,966</u>		<u>32,966</u>	8
9	V	<u>17 Corporate Administration</u>	<u>709,305</u>					<u>(709,305)</u>	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ <u>709,305</u>			\$ <u>755,383</u>	\$ *	<u>46,078</u>	14

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

Facility Name & ID Number

Smith Crossing

#

0046698

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James J. Nemeč	Board Member	Trustee of the	None	2,093			Investment	\$ 3,294	27.3	1
2			Board and Owner								2
3			of Heritage Capital								3
4											4
5	Thomas E. Chomicz	Board Member	Trustee of the	None	9,421			Legal Services	18,967	19.3	5
6			Board and Partner								6
7			at Quarles & Brady								7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 22,261		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:

07/01/2008

Ending: 6/30/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Smith Senior Living
 Street Address 2320 West 113th Place
 City / State / Zip Code Chicago, IL 60643
 Phone Number (773) 474-7350
 Fax Number (773) 474-7342

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional Services	Direct Cost	27,473,574	2	\$ 197,549	\$ 9,888,841	\$ 71,106	1
2	20	Fees, Subscriptions & Promo	Direct Cost	27,473,574	2	10,092	9,888,841	3,633	2
3	21	Clerical & General Office	Direct Cost	27,473,574	2	1,452,358	1,247,068	9,888,841	522,762
4	22	Employee Benefits	Direct Cost	27,473,574	2	297,634	9,888,841	107,130	4
5	23	Inservice Training & Education	Direct Cost	27,473,574	2	3,528	9,888,841	1,270	5
6	24	Travel & Seminars	Direct Cost	27,473,574	2	19,214	9,888,841	6,916	6
7	26	Insurance	Direct Cost	27,473,574	2	26,672	9,888,841	9,600	7
8	30	Depreciation	Direct Cost	27,473,574	2	91,586	9,888,841	32,965	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 2,098,633	\$ 1,247,068	\$ 755,382	25

Facility Name & ID Number

Smith Crossing

0046698

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bond - Series 2003A		X	Facility Construction	N/A	11/1/2003	\$ 20,110,000	\$ 19,730,000	11/15/2032	Variable	\$ 1,295,575	1							
2	Bond - Series 2003B-2		X	Facility Construction	N/A	11/1/2003	4,250,000	4,113,000	11/15/2033	0.0525	214,774	2							
3	Amortized Debt Issuance										199,170	3							
4												4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 24,360,000	\$ 23,843,000			\$ 1,709,519	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 24,360,000	\$ 23,843,000			\$ 1,709,519	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:

07/01/2008 Ending:

06/30/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 260,639 B. General Construction Type: Exterior Brick / Siding Frame _____ Number of Stories 4

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

87 Independent Living Apartments, 171,052 Square Feet (included in square footage listed in A Above)

32 Assisted Living Apartments, 27,743 Square Feet (included in square footage listed in A above)

16 Memory Care Apartments, 17,342 Square Feet (included in square footage listed in A above)

10 Cottages, 21,034 Square Feet (included in square footage listed in A above)

Smith Crossing is a CCRC which includes the nursing facility and services listed above. All non-nursing facility costs have been adjusted out on Pages 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Land</u>		<u>2001</u>	<u>\$ 6,452,639</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 6,452,639	3

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	30			2005	\$ 39,226,430	\$ 980,470	40	\$ 980,470	\$	\$ 4,388,293	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	2,245	449	5	449		1,609	9
10	Various			2005	2,217	222	10	222		834	10
11	Various			2005	6,600	440	15	440		1,577	11
12	Awnings - Main Dining Room			2006	2,245	449	5	449		1,572	12
13	Plumbing Fixtures			2006	1,037	52	20	52		164	13
14	Concrete Pads for Park Benches			2006	2,300	115	20	115		335	14
15	Lifeline Watchmate Id Doorpak			2006	2,004	100	20	100		276	15
16	Kinsella - Landscaping			2006	40,000	4,000	10	4,000		11,000	16
17	Initial Electronics - Security			2006	6,216	622	10	622		1,709	17
18	Midwest Mechanical - Kithchen HVAC			2006	66,020	6,052	10	6,052		11,773	18
19	Rick Workmans - Carpeting 2416 & 2406			2006	2,251	450	5	450		1,313	19
20	Rick Workmans - Carpeting - Cottage 1042			2006	2,172	435	5	435		1,159	20
21	Rick Workmans - Carpeting - Cottage 3201			2006	2,803	561	5	561		1,448	21
22	Illinois Pump Inc - Irrigation Pump Installation			2006	9,986	999	10	999		2,580	22
23	Rick Workmans - Carpeting - 2410 / 1406 / 1416			2006	4,462	892	5	892		2,380	23
24	Rick Workmans - Carpeting - 1108 / 2408			2006	3,226	645	5	645		1,721	24
25	Rick Workmans - Carpeting - 1102			2006	3,215	643	5	643		1,822	25
26	Rick Workmans - Carpeting - 3101			2006	2,078	416	5	416		1,212	26
27	Rick Workmans - Carpeting - 1402			2006	990	198	5	198		561	27
28	Rick Workmans - Carpeting - 2416 / 2406			2007	2,712	542	5	542		1,311	28
29	Rick Workmans - Carpeting - 2103			2007	591	118	5	118		286	29
30	Rick Workmans - Carpeting - 1109			2007	6,559	1,312	5	1,312		3,170	30
31	Kinsella - Landscaping			2007	19,083	1,908	10	1,908		4,294	31
32	Flooring America - Carpeting - 1210			2007	3,420	684	5	684		1,482	32
33	Flooring America - Tile - 1104 / 2305			2007	1,166	233	5	233		486	33
34	The Little Guys - Screen w/ Microphones			2007	1,800	180	10	180		375	34
35	Home Depot - Carbon Monoxide Dectectors			2007	5,358	1,072	5	1,072		2,233	35
36	Flooring America - Tile/Carpeting - 10432 / 2414			2007	1,587	317	5	317		661	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:

07/01/2008 Ending: 06/30/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Kinsella - Landscaping	2007	\$ 3,700	\$ 370	10	\$ 370	\$	\$ 771	37
38	Kinsella - Landscaping	2007	5,875	588	10	588		1,224	38
39	Flooring America - Carpeting - H2	2008	1,127	225	5	225		451	39
40	Flooring America - Carpeting - 2104	2008	3,723	745	5	745		1,427	40
41	Flooring America - Hardwood Flooring - 10410/10418/10420	2008	17,804	1,780	10	1,780		3,116	41
42	Flooring America - Carpeting - 1209 / 2303	2008	8,101	1,620	5	1,620		2,430	42
43	Flooring America - Carpeting - 1403 / 1410	2008	2,790	558	5	558		837	43
44	Flooring America - Carpeting - 2410	2008	1,263	253	5	253		358	44
45	Flooring America - Vinyl Flooring - 1405 Kitchen	2008	626	63	10	63		89	45
46	Flooring America - Carpeting - 1413/1405/2306	2008	5,829	1,166	5	1,166		1,652	46
47	Flooring America - Carpeting - 2409	2008	1,728	346	5	346		484	47
48	Flooring America - Carpeting - 2405 / 3204	2008	6,183	1,237	5	1,237		1,649	48
49	Flooring America - Carpeting - 2405 / 3204	2008	2,127	425	5	425		567	49
50	Flooring America - Carpeting - Cottage 10430	2008	9,954	1,991	5	1,991		2,323	50
51	Flooring America - Carpeting - 2407	2008	2,493	499	5	499		582	51
52	Flooring America - Carpeting - 2202/1414/1203	2008	11,730	2,346	5	2,346		2,542	52
53	AG Architecture - Screen Porch	2008	5,718	1,048	5	1,048		1,048	53
54	AG Architecture - Add Elevators to Existing Generator	2008	3,690	138	20	138		138	54
55	Creative Carpet - 2403	2008	1,076	99	10	99		99	55
56	Creative Carpet - 10410	2008	1,945	357	5	357		357	56
57	Creative Carpet - 2206	2008	3,257	299	10	299		299	57
58	Creative Carpet - 10408	2008	2,581	473	5	473		473	58
59	Creative Carpet - 1415	2008	534	89	5	89		89	59
60	Creative Carpet - 2206	2008	1,994	332	5	332		332	60
61	Creative Carpet - 1308	2008	1,912	287	5	287		287	61
62	Creative Carpet - 1406	2008	1,010	151	5	151		151	62
63	Creative Carpet - 10430	2008	578	39	10	39		39	63
64	Creative Carpet - 3207	2008	1,927	257	5	257		257	64
65	Creative Carpet - 3203	2008	2,924	341	5	341		341	65
66	Creative Carpet - 2208	2009	1,336	134	5	134		134	66
67	Creative Carpet - J1	2009	548	46	5	46		46	67
68	Creative Carpet - 2401	2009	1,041	87	5	87		87	68
69	Creative Carpet - 2411	2009	1,085	90	5	90		90	69
70	TOTAL (lines 4 thru 69)		\$ 39,548,982	\$ 1,023,052		\$ 1,023,052	\$	\$ 4,472,400	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:

07/01/2008 Ending: 06/30/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 39,548,982	\$ 1,023,052		\$ 1,023,052	\$	\$ 4,472,400	1
2	Creative Carpet - 1108	2009	1,232	103		103		103	2
3	Creative Carpet	2009	689	46		46		46	3
4	Creative Carpet	2009	689	46		46		46	4
5	Creative Carpet - 3104	2009	1,989	133		133		133	5
6	Creative Carpet - 2404	2009	1,048	70		70		70	6
7	Creative Carpet	2009	306	20		20		20	7
8	Creative Carpet - 2408	2009	528	26		26		26	8
9	Creative Carpet - 1407	2009	516	17		17		17	9
10	Creative Carpet - 2104	2009	1,577	26		26		26	10
11	Flooring America- Carpet - 3103	2009	5,078	508		508		508	11
12	J & L Metal Doors - Fire Exit Door Hardward	2009	1,631	109		109		109	12
13	Ronald Anderson - Paint 10408	2009	7,400	1,233		1,233		1,233	13
14	The Geo Group - Villas - Enclosed 3 Season Porches	2009	32,000	2,133		2,133		2,133	14
15	The Geo Group - Villas - Enclosed 3 Season Porches	2009	50,730	3,382		3,382		3,382	15
16	The Geo Group - Villas - Enclosed 3 Season Porches	2009	900	60		60		60	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 39,655,296	\$ 1,030,964		\$ 1,030,964	\$	\$ 4,480,313	34

**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:

07/01/2008

Ending:

06/30/2009

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,184,891	\$ 109,650	\$ 109,650	\$		\$ 480,240	71
72	Current Year Purchases	70,046	6,767	6,767			6,767	72
73	Fully Depreciated Assets	2,275	350	350			2,275	73
74								74
75	TOTALS	\$ 1,257,212	\$ 116,767	\$ 116,767	\$		\$ 489,282	75

D. Vehicle Depreciation (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	\$ 6,400	\$ 6,400	\$	4	\$ 61,437	76
77	CCRC	2000 Ford Pickup	2005	13,933	3,483	3,483		4	12,482	77
78	CCRC	Chevy Impala	2006	19,535	4,884	4,884		4	13,023	78
79										79
80	TOTALS			\$ 94,905	\$ 14,767	\$ 14,767	\$		\$ 86,942	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)	\$ 47,460,053	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,162,499	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,162,499	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)	\$ 5,056,538	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10.3	hrs			872	\$ 58,662					872	\$ 58,662			1
2	Licensed Speech and Language Development Therapist	10.3	hrs			32	2,839					32	2,839			2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10.3	hrs			1,184	79,900					1,184	79,900			4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	TOTAL				\$	2,087	\$ 141,400	\$				2,087	\$ 141,400			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# 0046698Report Period Beginning: 07/01/2008Ending: 06/30/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 655,711	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	137,851		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,302		6
7	Other Prepaid Expenses	22,248		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Bond Funds Current</u>	423,827		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,241,940	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,740,658		12
13	Land	6,452,639		13
14	Buildings, at Historical Cost	39,226,430		14
15	Leasehold Improvements, at Historical Cost	428,866		15
16	Equipment, at Historical Cost	1,352,117		16
17	Accumulated Depreciation (book methods)	(5,056,538)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	3,981,626		21
22	Other Long-Term Assets (spe <u>Bond Issuance</u>)	1,146,683		22
23	Other(specify): <u>Continuing-care Contracts</u>	910,893		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 51,183,374	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 52,425,314	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 820,485	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	315,322		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	204,087		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	187,668		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Resident Credit Balances</u>	17,801		36
37	<u>Other Current Liabilities</u>	297,119		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,842,482	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	23,732,219		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to Affiliate</u>	1,305,917		43
44	<u>Refundable & Non-Refundable Entrance F</u>	22,806,425		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 47,844,561	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 49,687,043	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,738,272	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 52,425,315	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 5,002,988	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 5,002,988	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,264,715)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,264,715)	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)	\$ 2,738,273	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Smith Crossing# 0046698Report Period Beginning: 07/01/2008Ending: 06/30/2009**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,541,224	1
2	Discounts and Allowances for all Levels	(416,237)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,124,987	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	327,756	6
7	Oxygen	4	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 327,760	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	45,778	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	49,908	15
16	Rental of Facility Space	8,506	16
17	Sale of Drugs	85,900	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,955	19
20	Radiology and X-Ray	5,253	20
21	Other Medical Services	63,835	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 272,135	23
D. Non-Operating Revenue			
24	Contributions	1,409	24
25	Interest and Other Investment Income***	(225,121)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (223,712)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	122,956	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 122,956	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,624,126	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,492,185	31
32	Health Care	2,032,868	32
33	General Administration	2,078,689	33
B. Capital Expense			
34	Ownership	2,905,924	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	379,175	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,888,841	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,264,715)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,264,715)	43

* 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.

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

07/01/2008

Ending:

06/30/2009

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	2,014	2,143	\$ 82,494	\$ 38.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,434	7,909	212,496	26.87	3
4	Licensed Practical Nurses	2,014	2,076	43,936	21.16	4
5	CNAs & Orderlies	49,525	54,725	595,786	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,082	2,142	37,710	17.61	9
10	Activity Assistants	10,820	11,933	118,468	9.93	10
11	Social Service Workers	1,832	2,066	55,703	26.96	11
12	Dietician					12
13	Food Service Supervisor	1,838	2,063	23,424	11.35	13
14	Head Cook	3,910	4,349	63,215	14.54	14
15	Cook Helpers/Assistants	53,541	56,799	554,639	9.76	15
16	Dishwashers					16
17	Maintenance Workers	18,236	20,297	271,379	13.37	17
18	Housekeepers	12,920	14,066	129,549	9.21	18
19	Laundry	3,037	3,299	29,623	8.98	19
20	Administrator	1,850	2,104	112,257	53.35	20
21	Assistant Administrator	1,755	2,104	37,070	17.62	21
22	Other Administrative	10,768	11,663	153,192	13.13	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,770	4,143	68,388	16.51	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS Coord	578	647	17,213	26.60	32
33	Other(specify) <u>Marketing</u>	3,376	3,684	67,170	18.23	33
34	TOTAL (lines 1 - 33)	191,300	208,212	\$ 2,673,712 *	\$ 12.84	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	12,000	9.3	36
37	Medical Records Consultant	3,073	10.3	37
38	Nurse Consultant			38
39	Pharmacist Consultant	126	10.3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	832	10.3	44
45	Social Service Consultant	493	10.3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 16,524		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5,521	\$ 196,234	10.3	50
51	Licensed Practical Nurses	3,670	143,866	10.3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,191	\$ 340,100		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Frank Guajardo	Exec Dir	0	\$ 112,257	Workers' Compensation Insurance	\$ 104,189	IDPH License Fee	\$	
Other Admin Wages (Reclassified to Line 21)			120,600	Unemployment Compensation Insurance		Advertising: Employee Recruitment	1,110	
				FICA Taxes	218,986	Health Care Worker Background Check	5,993	
				Employee Health Insurance	294,792	(Indicate # of checks performed)		
				Employee Meals	29,370	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subs	7,623	
				Disability Insurance	4,236	AASHA Dues	4,417	
				Life Insurance	2,155	Other Taxes & Fees	78,040	
				Pension Expense	148,913			
				Tuition Reimbursement	400			
				Employee Recognition	2,037	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 232,857	TOTAL (agree to Schedule V, line 22, col.8)	\$ 805,078	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 97,183	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Smith Senior Living - Corporate Administration			\$ 709,305				Out-of-State Travel	\$ 1,229
							In-State Travel	555
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 709,305				Seminar Expense	9,724
C. Professional Services				TOTAL			Entertainment Expense ()	
Vendor/Payee	Type		Amount				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 11,508
Chicago Title Insurance	Title Search		\$ 60					
Crowe Horwath, LLP	Accounting Services		24,500					
Paylocity	Payroll Services		10,428					
Quarles & Brady	Legal Services		23,174					
R.L. Milles & Assoc	Design / Engineering		6,358					
Seyfarth Shaw	Legal Services		155					
Other	Accrual / NICOR Refund		(990)					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 63,684					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Smith Crossing# 0046698Report Period Beginning: 07/01/2008Ending: 06/30/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network (LSN) \$4,417
- (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? _____
- (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? _____
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,041 Line 10
- (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. _____
- (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. \$ 16,630
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. \$ 29,370 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (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? Yes
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: Crowe Horwath, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.