

Facility Name & ID Number Smith Crossing

0046698 Report Period Beginning: 7/1/12 Ending: 6/30/13

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	16,790	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	46	TOTALS	46	16,790	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	1,955	6,420	6,523	14,898	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,955	6,420	6,523	14,898	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.73%

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 10/15/2005

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

YES Date 11/1/2003 NO

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

YES NO If YES, enter number of beds certified 46 and days of care provided 5,414

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: 6/30/2013 Fiscal Year: 6/30/2013

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

Facility Name & ID Number

Smith Crossing

0046698

Report Period Beginning:

7/1/12

Ending:

6/30/13

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	762,891	92,273	501,105	1,356,269		1,356,269	(1,098,849)	257,420		1
2	Food Purchase		796,867		796,867		796,867	(685,447)	111,420		2
3	Housekeeping	312,557	31,913	216	344,686		344,686	(292,880)	51,806		3
4	Laundry	55,464	11,755	265	67,484		67,484	(56,234)	11,250		4
5	Heat and Other Utilities			388,001	388,001		388,001	(323,316)	64,685		5
6	Maintenance	234,920	9,118	681,612	925,650		925,650	(771,970)	153,680		6
7	Other (specify):*										7
8	TOTAL General Services	1,365,832	941,926	1,571,199	3,878,957		3,878,957	(3,228,695)	650,262		8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	1,067,285	57,144	1,212,210	2,336,639		2,336,639	(690,440)	1,646,199		10
10a	Therapy			466,704	466,704		466,704		466,704		10a
11	Activities	207,033	4,848	159,855	371,736		371,736	(315,598)	56,138		11
12	Social Services	59,137		572	59,709		59,709	(49,755)	9,954		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,333,455	61,992	1,850,341	3,245,788		3,245,788	(1,055,792)	2,189,996		16
	C. General Administration										
17	Administrative					127,073	127,073		127,073		17
18	Directors Fees										18
19	Professional Services			15,535	15,535		15,535	63,599	79,134		19
20	Dues, Fees, Subscriptions & Promotions			28,606	28,606		28,606	(907)	27,699		20
21	Clerical & General Office Expenses	282,062	9,699	1,289,385	1,581,146	(127,073)	1,454,073	(566,627)	887,446		21
22	Employee Benefits & Payroll Taxes			762,848	762,848		762,848	92,071	854,919		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,122	13,122		13,122	11,425	24,547		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			109,579	109,579		109,579	(76,438)	33,141		26
27	Other (specify):*										27
28	TOTAL General Administration	282,062	9,699	2,219,075	2,510,836		2,510,836	(476,877)	2,033,959		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,981,349	1,013,617	5,640,615	9,635,581		9,635,581	(4,761,365)	4,874,216		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.

STATE OF ILLINOIS

0046698

Report Period Beginning 7/1/2012 Ending:

Part V Supplement

6/30/2013

Facility Name & Smith Crossing

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule	To Line	From Line
Reclassify administrator wages \$ 127,073	17	21

Facility Name & ID Number Smith Crossing

#0046698

Report Period Beginning:

7/1/12

Ending:

6/30/13

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			1,927,752	1,927,752	1,927,752	(1,571,086)	356,666				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,049,652	2,049,652	2,049,652	(1,707,947)	341,705				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,694	9,694	9,694	(8,078)	1,616				35
36	Other (specify):*											36
37	TOTAL Ownership			3,987,098	3,987,098	3,987,098	(3,287,111)	699,987				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			323,459	323,459	323,459	(1,128)	322,331				39
40	Barber and Beauty Shops			73,886	73,886	73,886	(73,886)					40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,185	25,185	25,185		25,185				42
43	Other (specify):* Marketing	197,066	2,441	334,148	533,655	533,655	(533,655)					43
44	TOTAL Special Cost Centers	197,066	2,441	756,678	956,185	956,185	(608,669)	347,516				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,178,415	1,016,058	10,384,391	14,578,864	14,578,864	(8,657,145)	5,921,719				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: 7/1/12

Ending: 6/30/13

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	\$ (1,128)	39	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(40,223)	2		4
5	Telephone, TV & Radio in Resident Rooms	(25,892)	21		5
6	Rented Facility Space	(5,658)	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	(14,365)	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)	(638)	6		16
17	Non-Care Related Fees	(5,835)	11		17
18	Fines and Penalties	(580)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(533,655)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(7,869,636)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,497,610)		\$	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)			34
35	Other- Attach Schedule	(159,535)	VII-B	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (159,535)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (8,657,145)		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.			\$		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

BHF USE ONLY						
48		49		50		51
						52

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	AL/IL dietary costs	\$ (1,098,849)	1	1
2	AL/IL food purchases	(645,621)	2	2
3	AL/IL housekeeping	(287,222)	3	3
4	AL/IL laundry	(56,234)	4	4
5	AL/IL heat & other utilities	(323,316)	5	5
6	AL/IL maintenance	(771,332)	6	6
7	AL/IL nursing costs	(690,440)	10	7
8	AL/IL activities	(309,763)	11	8
9	AL/IL Social Services	(49,755)	12	9
10	AL/IL Dues, fees, subs	(907)	20	10
11	AL/IL office & clerical	(19,811)	21	11
12	Miscellaneous income	(2,851)	21	12
13	Medication Setup income	(41,568)	21	13
14	AL/IL nursing & activities emp benefits	(84,201)	22	14
15	AL/IL travel & seminar	(175)	24	15
16	AL/IL insurance	(91,311)	26	16
17	AL/IL depreciation	(1,606,370)	30	17
18	AL/IL bond interest	(1,707,947)	32	18
19	AL/IL equipment rent	(8,078)	35	19
20	Beauty shop income	(73,886)	40	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	(7,869,636)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Crossing# 0046698

Report Period Beginning:

7/1/12

Ending:

6/30/13

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	(1,098,849)	0	0	0	0	0	0	0	0	0	0	(1,098,849)	1
2	Food Purchase	(685,844)	397	0	0	0	0	0	0	0	0	0	(685,447)	2
3	Housekeeping	(292,880)	0	0	0	0	0	0	0	0	0	0	(292,880)	3
4	Laundry	(56,234)	0	0	0	0	0	0	0	0	0	0	(56,234)	4
5	Heat and Other Utilities	(323,316)	0	0	0	0	0	0	0	0	0	0	(323,316)	5
6	Maintenance	(771,970)	0	0	0	0	0	0	0	0	0	0	(771,970)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,229,092)	397	0	(3,228,695)	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	(690,440)	0	0	0	0	0	0	0	0	0	0	(690,440)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(315,598)	0	0	0	0	0	0	0	0	0	0	(315,598)	11
12	Social Services	(49,755)	0	0	0	0	0	0	0	0	0	0	(49,755)	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	(1,055,792)	0	0	0	0	0	0	0	0	0	0	(1,055,792)	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	63,599	0	0	0	0	0	0	0	0	0	63,599	19
20	Fees, Subscriptions & Promotions	(907)	0	0	0	0	0	0	0	0	0	0	(907)	20
21	Clerical & General Office Expenses	(105,067)	(461,560)	0	0	0	0	0	0	0	0	0	(566,627)	21
22	Employee Benefits & Payroll Taxes	(84,201)	176,272	0	0	0	0	0	0	0	0	0	92,071	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(175)	11,600	0	0	0	0	0	0	0	0	0	11,425	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(91,311)	14,873	0	0	0	0	0	0	0	0	0	(76,438)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(281,661)	(195,216)	0	(476,877)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,566,546)	(194,819)	0	(4,761,365)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Crossing# 0046698

Report Period Beginning:

7/1/12

Ending:

6/30/13

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,606,370)	35,284	0	0	0	0	0	0	0	0	0	(1,571,086)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,707,947)	0	0	0	0	0	0	0	0	0	0	(1,707,947)	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	(8,078)	0	0	0	0	0	0	0	0	0	0	(8,078)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,322,395)	35,284	0	(3,287,111)	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	(1,128)	0	0	0	0	0	0	0	0	0	0	(1,128)	39
40	Barber and Beauty Shops	(73,886)	0	0	0	0	0	0	0	0	0	0	(73,886)	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):*	(533,655)	0	0	0	0	0	0	0	0	0	0	(533,655)	43
44	TOTAL Special Cost Centers	(608,669)	0	0	0	0	0	0	0	0	0	0	(608,669)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(8,497,610)	(159,535)	0	0	0	0	0	0	0	0	0	(8,657,145)	45

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
		<u>Smith Village</u>	<u>Chicago</u>	<u>Smith Senior Living</u>	<u>Chicago</u>	<u>Home Office</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 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	<u>2 Food Purchases</u>	\$	<u>Smith Senior Living</u>		\$ <u>397</u>	\$ <u>397</u> 1
2	V	<u>19 Professional Serivces</u>		<u>Smith Senior Living</u>		<u>63,599</u>	<u>63,599</u> 2
3	V	<u>21 Clerical & General Office Exp</u>		<u>Smith Senior Living</u>		<u>674,098</u>	<u>674,098</u> 3
4	V	<u>22 PR Taxes & Employee Benefits</u>		<u>Smith Senior Living</u>		<u>176,272</u>	<u>176,272</u> 4
5	V	<u>24 Travel and Seminar</u>		<u>Smith Senior Living</u>		<u>11,600</u>	<u>11,600</u> 5
6	V	<u>26 Insurance</u>		<u>Smith Senior Living</u>		<u>14,873</u>	<u>14,873</u> 6
7	V	<u>30 Depreciation</u>		<u>Smith Senior Living</u>		<u>35,284</u>	<u>35,284</u> 7
8	V						8
9	V						9
10	V						10
11	V	<u>21 Management Fees</u>	<u>1,135,658</u>				<u>(1,135,658)</u> 11
12	V						12
13	V						13
14	Total		\$ <u>1,135,658</u>			\$ <u>976,123</u>	\$ * <u>(159,535)</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: 7/1/12 Ending: 6/30/13

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	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A							\$		1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$		13

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

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

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

7/1/12

Ending: 6/30/13

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) 474-7352

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	2	Food Purchases	Direct Costs	30,947,925	2	\$ 1,138	\$ 11,665,530	\$ 429	1
2	19	Professional Services	Direct Costs	30,947,925	2	182,957	11,665,530	68,964	2
3	21	Clerical & General Office Exp	Direct Costs	30,947,925	2	1,939,219	1,541,791	730,970	3
4	22	PR Taxes & Employee Benefits	Direct Costs	30,947,925	2	507,096	11,665,530	191,145	4
5	24	Travel and Seminar	Direct Costs	30,947,925	2	33,370	11,665,530	12,579	5
6	26	Insurance	Direct Costs	30,947,925	2	42,785	11,665,530	16,127	6
7	30	Depreciation	Direct Costs	30,947,925	2	101,503	11,665,530	38,261	7
8							11,665,530		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					\$ 2,808,068	\$ 1,541,791	\$ 1,058,475	25

Facility Name & ID Number

Smith Crossing

0046698

Report Period Beginning:

7/1/12

Ending:

6/30/13

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Bond - Series 2003A		X	Facility Construction	N/A	11/1/2003	\$ 20,110,000	\$ 18,010,000	11/15/2032	Variable	\$ 1,772,380	1						
2	Bond - Series 2003B-2		X	Facility Construction	N/A	11/1/2003	4,250,000	4,113,000	11/15/2033	0.0525	277,272	2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 24,360,000	\$ 22,123,000			\$ 2,049,652	9						
B. Non-Facility Related*																		
10	Remove AL/IL portion of Interest Expense											10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 24,360,000	\$ 22,123,000			\$ 2,049,652	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 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 2013 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:	2008	_____	8	FOR BHF USE ONLY		
	2009	_____	9			
	2010	_____	10			
	2011	_____	11			
	2012	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Smith Crossing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046698

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Smith Crossing

0046698 Report Period Beginning:

7/1/12 Ending:

6/30/13

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

Smith Crossing, Independent Living - 149,119 square feet - 97 units

Smith Crossing, Assisted Living - 19,704 square feet, 48 units

Smith Crossing is a CCRC which includes the nursing facility and services listed above. All non- nursing facility costs have been adjusted out on page 5 and 5^A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			2001	\$ 6,452,639	1
2					2
3	TOTALS			\$ 6,452,639	3

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

7/1/12

Ending:

6/30/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	30		2005	\$ 39,226,430	\$	40	\$	\$	4
5	16		2012	7,235,761		20			5
6									6
7									7
8									8
Improvement Type**									
9	Various		2005	351		10			9
10	Various		2006	2,307		10			10
11	Various		2007	3,735		10			11
12	Flooring America - Carpeting - H2		2008	1,127		5			12
13	Flooring America - Carpeting - 2104		2008	3,723		5			13
14	Flooring America - Hardwood Flooring - 10410/10418/10420		2008	17,804		10			14
15	Flooring America - Carpeting 1209 / 2303		2008	8,101		5			15
16	Flooring America - Carpeting - 1403 / 1410		2008	2,790		5			16
17	Flooring America - Carpeting - 2410		2008	1,263		5			17
18	Flooring America - Vinyl Flooring - 1405 Kitchen		2008	626		10			18
19	Flooring America - Carpeting - 1413 / 1405 / 2306		2008	5,829		5			19
20	Flooring America - Carpeting - 2409		2008	1,728		5			20
21	Flooring America - Carpeting - 2405 / 3204		2008	6,183		5			21
22	Flooring America - Carpeting - 2405 / 3204		2008	2,127		5			22
23	Flooring America - Carpeting - Cottage 10430		2008	9,954		5			23
24	Flooring America - Carpeting - 2407		2008	2,493		5			24
25	Flooring America - Carpeting - 2202 / 1414/ 1203		2008	11,730		5			25
26	AG Architecture - Screen Porch		2008	5,718		5			26
27	AG Architecture - Add Elevators to Existing Generator		2008	3,690		20			27
28	Creative Carpet - 2403		2008	1,076		10			28
29	Creative Carpet - 10410		2008	1,945		5			29
30	Creative Carpet - 2206		2008	3,257		10			30
31	Creative Carpet - 10408		2008	2,581		5			31
32	Creative Carpet - 1415		2008	534		5			32
33	Creative Carpet - 2206		2008	1,994		5			33
34	Creative Carpet - 1308		2008	1,912		5			34
35	Creative Carpet - 1406		2008	1,010		5			35
36	Creative Carpet - 10430		2008	578		10			36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

7/1/12

Ending:

6/30/13

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Creative Carpet - 3207	2008	\$ 1,927	\$	5	\$	\$	\$	37
38	Creative Carpet - 3203	2008	2,924		5				38
39	Creative Carpet - 2208	2009	1,336		5				39
40	Creative Carpet - J1	2009	548		5				40
41	Creative Carpet - 2401	2009	1,041		5				41
42	Creative Carpet - 2411	2009	1,085		5				42
43	Creative Carpet - 1108	2009	1,232		5				43
44	Creative Carpet	2009	689		5				44
45	Creative Carpet	2009	689		5				45
46	Creative Carpet - 3104	2009	1,989		5				46
47	Creative Carpet - 2404	2009	1,048		5				47
48	Creative Carpet	2009	306		5				48
49	Creative Carpet - 2408	2009	528		5				49
50	Creative Carpet - 1407	2009	516		5				50
51	Creative Carpet - 2104	2009	1,577		5				51
52	Flooring America - Carpet - 3103	2009	5,078		5				52
53	J&L Metal Doors - Fire Exit Door Hardware	2009	1,631		5				53
54	Ronald anerson - Paint 10408	2009	7,400		5				54
55	The Geo Group - Villas - Enclosed 3 Season Porches	2009	32,000		5				55
56	The Geo Group - Villas - Enclosed 3 Season Porches	2009	50,730		5				56
57	The Geo Group - Villas - Enclosed 3 Season Porches	2009	900		5				57
58	McCabe - Carpeting	2009	2,000		5				58
59	Creative Carpet	2009	5,501		5				59
60	Creative Carpet	2010	21,758		5				60
61	Greenway Landscape Nursery	2010	29,464		5				61
62	Home Depot Supply	2010	1,393		7				62
63	2-Wire System	2011	20,000		10				63
64	Carpeting 12 II units 6 AL units 2 Skilled units 1 repair	2011	30,356		5				64
65	Landscaping	2011	135		5				65
66	Dyrwall and painting - remodeled marketing area	2011	1,800		5				66
67	Marketing Area Enclosure	2011	3,911		5				67
68	Remove and repair sidewalks	2011	2,600		20				68
69	Vinyl Independent living units	2012	681		5				69
70	TOTAL (lines 4 thru 69)		\$ 46,803,130	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 46,803,130	\$		\$	\$	\$	1
2	Carpeting	2012	42,476		5				2
3	Thermocore Door	2012	4,016		10				3
4	Sprinkler Repair	2012	6,057		5				4
5	Fountain Winterizing	2012	300		5				5
6	SC Phase 2A	2012	194,994		15				6
7	SC Phase 2C	2012	358,943		15				7
8	Spring Fountain Install/Sprinkler Repair	2012	3,850		5				8
9	Sprinkler Repair	2012	844		5				9
10	SC Phase 2B	2013	27,750,890		15				10
11	SC Phase 2	2013	276,916		15				11
12	Total Building & Building Improvements Depreciation Expense			1,802,654		1,802,654		9,722,262	12
13	Less: AL/IL Depreciation			(1,606,370)		(1,606,370)			13
14	Add: Home Office Allocation			35,284		35,284			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
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 75,442,417	\$ 231,568		\$ 231,568	\$	\$ 9,722,262	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,788,308	\$ 71,965	\$ 71,965	\$	Various	\$ 874,873	71
72	Current Year Purchases	575,537	46,394	46,394	0	Various	46,394	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,363,845	\$ 118,359	\$ 118,359	\$ 0		\$ 921,267	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	CCRC	Passenger Bus	2004	\$ 61,437	\$	\$	\$	5	\$ 61,437	76
77	CCRC	2000 Ford Pickup	2005	13,933				5	13,933	77
78	CCRC	Chevy Impala	2006	19,535				5	19,535	78
79	CCRC	Passenger Bus	2011	71,883	6,739	6,739		15	20,217	79
80	TOTALS			\$ 166,788	\$ 6,739	\$ 6,739	\$		\$ 115,122	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 84,425,689	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 356,666	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 356,666	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,758,651	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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/1/12 Ending: 6/30/13
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><u>CNA's have received training and certification prior to being hired with Smith Crossing.</u></p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$	3,017	\$ 207,896	\$	3,017	\$ 210,577	1	
2	Licensed Speech and Language Development Therapist	10.3	hrs		474	36,506		474	36,977	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10.3	hrs		2,985	216,360		2,985	219,150	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			\$	6,476	\$ 460,762	\$	6,476	\$ 466,704	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: 7/1/12

Ending:

6/30/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/13

(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	\$ 1,497,601	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>5,404</u>)	584,697		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	84,510		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,166,808	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,917,055		12
13	Land	6,452,639		13
14	Buildings, at Historical Cost	75,442,417		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,530,633		16
17	Accumulated Depreciation (book methods)	(10,758,651)		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 (spec <u>Bond Funds</u>)	7,256,950		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 83,841,043	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 86,007,851	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 2,427,838	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	295,345		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	182,532		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Supplemental Schedule</u>	3,425,723		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,331,438	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	43,637,136		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Supplemental Schedule</u>	37,345,204		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 80,982,340	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 87,313,778	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,305,927)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 86,007,851	\$	48

*(See instructions.)

SCHEDULE XV. BALANCE SHEET - Supplemental Schedule

Line 36 - Other Current Liabilities

<u>Description</u>	<u>Amount</u>
Resident credit balances	\$ 112,976
Deposits-AL/Skilled	\$ 38,080
Deposits - IL Wait List	\$ 7,637
Deposit Escrow Liability	\$ 332,248
IC - Due to/from Related	\$ 2,592,782
	<u>\$ 5,541,392</u>

Line 43 - Other Long-Term Liabilities

<u>Description</u>	<u>Amount</u>
Note payable to affiliate - Smith Senior Living	\$ 680,140
Refundable entrance fees	33,683,914
Deferred revenue from non-refundable entrance fees	2,981,150
	<u>#####</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (358,303)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (358,303)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(947,624)	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)	\$ (947,624)	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)	\$ (1,305,927)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 13,122,370	1
2	Discounts and Allowances for all Levels	(1,506,854)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,615,516	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	948,418	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 948,418	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	82,834	13
14	Non-Patient Meals	109,306	14
15	Telephone, Television and Radio	29,675	15
16	Rental of Facility Space	11,658	16
17	Sale of Drugs	214,000	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	54,006	19
20	Radiology and X-Ray	19,617	20
21	Other Medical Services	339,389	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 860,485	23
D. Non-Operating Revenue			
24	Contributions	20,447	24
25	Interest and Other Investment Income***	137,354	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 157,801	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	52,020	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52,020	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,634,240	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	3,878,957	31
32	Health Care	3,245,788	32
33	General Administration	2,510,836	33
B. Capital Expense			
34	Ownership	3,987,098	34
C. Ancillary Expense			
35	Special Cost Centers	397,345	35
36	Provider Participation Fee	25,185	36
D. Other Expenses (specify):			
37	<u>Marketing Expenses</u>	533,655	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,578,864	40
41	Income before Income Taxes (line 30 minus line 40)**	(944,624)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (944,624)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 195,638	44
45	Private Pay - Net Inpatient Revenue	8,683,361	45
46	Medicare - Net Inpatient Revenue	2,542,972	46
47	Other-(specify) <u>Hospice</u>	193,457	47
48	Other-(specify) <u>Third-Party</u>	88	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,615,516	49

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

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

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

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

SCHEDULE XVII. INCOME STATEMENT - Supplemental Schedule**Line 25 Interest and Other Investment Income**

Income reported on this line is related to unrealized gain/loss and restricted funds, and therefore, has not been offset against interest expense reported on Schedule V, line 32.

Line 28 Other Revenue

<u>Description</u>	<u>Amount</u>
Resident transport - private pay	\$ 638
Miscellaneous income	2,851
Adult Day Care	1,128
Activities income	5,835
Medication Setup / Admin	41,568
	<u>\$ 49,062</u>

Facility Name & ID Number **Smith Crossing**

0046698

Report Period Beginning:

7/1/12

Ending:

6/30/13

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	1,988	2,042	\$ 86,971	\$ 42.59	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	87,905	88,451	1,052,724	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,988	2,010	36,628	18.22	9
10	Activity Assistants	13,867	13,961	184,503	13.22	10
11	Social Service Workers	9,843	9,965	203,409	20.41	11
12	Dietician					12
13	Food Service Supervisor	2,013	2,030	26,190	12.90	13
14	Head Cook	14,849	14,951	203,290	13.60	14
15	Cook Helpers/Assistants	42,160	42,293	415,880	9.83	15
16	Dishwashers					16
17	Maintenance Workers	15,574	15,701	215,831	13.75	17
18	Housekeepers	26,690	26,838	279,708	10.42	18
19	Laundry	3,920	3,944	38,660	9.80	19
20	Administrator	1,989	2,067	127,606	61.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,962	11,021	146,091	13.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: <u>Marketing</u>	7,889	7,996	171,924	21.50	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,637	243,270	\$ 3,189,415 *	\$ 13.11	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			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant			39	
40	Physical Therapy Consultant			40	
41	Occupational Therapy Consultant			41	
42	Respiratory Therapy Consultant			42	
43	Speech Therapy Consultant			43	
44	Activity Consultant	10	778	11.3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	10	\$ 778		49

C. CONTRACT NURSES

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

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
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16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Smith Crossing# 0046698Report Period Beginning: 7/1/12Ending: 6/30/13**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 & AAHSA \$11,763
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,465 Line 10.2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 25,185
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes (ALIL) For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 40,223 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftoLarsonAllen 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.