

Facility Name & ID Number Smith Crossing

0046698 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	863	9,231	4,616	14,710	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	863	9,231	4,616	14,710	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.61%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

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

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

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

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 4,616

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: 6/30/2018 Fiscal Year: 6/30/2018

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2017 Ending: 06/30/2018

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	919,658	114,945	544,274	1,578,877		1,578,877	(1,332,374)	246,503		1
2	Food Purchase		984,505		984,505		984,505	(918,311)	66,194		2
3	Housekeeping	403,120	38,217	9,835	451,172		451,172	(339,753)	111,419		3
4	Laundry	44,230	15,166	47	59,443		59,443	(43,619)	15,824		4
5	Heat and Other Utilities			538,643	538,643		538,643	(395,250)	143,393		5
6	Maintenance	372,740	18,621	844,741	1,236,102		1,236,102	(907,525)	328,577		6
7	Other (specify):*										7
8	TOTAL General Services	1,739,748	1,171,454	1,937,540	4,848,742		4,848,742	(3,936,831)	911,911		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,204,034	65,100	1,706,597	2,975,731		2,975,731	(929,169)	2,046,562		10
10a	Therapy		1,583	563,970	565,553	(565,553)					10a
11	Activities	295,077	7,979	159,396	462,452		462,452	(349,288)	113,164		11
12	Social Services	66,317	5,918	975	73,210		73,210	(53,721)	19,489		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,565,428	80,580	2,445,938	4,091,946	(565,553)	3,526,393	(1,332,178)	2,194,215		16
	C. General Administration										
17	Administrative					147,111	147,111		147,111		17
18	Directors Fees										18
19	Professional Services			68,622	68,622		68,622	11,343	79,965		19
20	Dues, Fees, Subscriptions & Promotions			59,025	59,025		59,025	(1,742)	57,283		20
21	Clerical & General Office Expenses	317,568	13,916	1,820,835	2,152,319	(147,111)	2,005,208	(1,370,862)	634,346		21
22	Employee Benefits & Payroll Taxes			954,825	954,825		954,825	242,360	1,197,185		22
23	Inservice Training & Education			6,417	6,417	7,184	13,601		13,601		23
24	Travel and Seminar			11,064	11,064	(7,184)	3,880	34,957	38,837		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			290,403	290,403		290,403	(192,467)	97,936		26
27	Other (specify):*										27
28	TOTAL General Administration	317,568	13,916	3,211,191	3,542,675		3,542,675	(1,276,411)	2,266,264		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,622,744	1,265,950	7,594,669	12,483,363	(565,553)	11,917,810	(6,545,420)	5,372,390		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.

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule	To Line	From Line
Reclassify administrator wages \$ 147,111	17	21

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			3,305,138	3,305,138		3,305,138	(2,384,557)	920,581			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,381,791	1,381,791		1,381,791	(351,417)	1,030,374			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			38,045	38,045		38,045	(27,917)	10,128			35
36	Other (specify):*											36
37	TOTAL Ownership			4,724,974	4,724,974		4,724,974	(2,763,891)	1,961,083			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,151	314,795	317,946	565,553	883,499		883,499			39
40	Barber and Beauty Shops	37,890	7,842	94,471	140,203		140,203		140,203			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,185	25,185		25,185		25,185			42
43	Other (specify):* Marketing	163,418	1,453	732,243	897,114		897,114	(897,114)				43
44	TOTAL Special Cost Centers	201,308	12,446	1,166,694	1,380,448	565,553	1,946,001	(897,114)	1,048,887			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,824,052	1,278,396	13,486,337	18,588,785		18,588,785	(10,206,424)	8,382,361			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	(90,147)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(8,688)	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	(902,884)	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)	(484)	6		16
17	Non-Care Related Fees	(9,946)	11		17
18	Fines and Penalties	(311)	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	(92,822)	21		24
25	Fund Raising, Advertising and Promotional	(897,114)	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 PG5A	(8,395,279)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,397,675)		\$	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)	191,251		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 191,251		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (10,206,424)		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

Smith Crossing

ID# 0046698

Report Period Beginning: 07/01/2017

Ending: 06/30/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	AL/IL dietary costs	\$ (1,332,374)	1	1
2	AL/IL food purchases	(830,799)	2	2
3	AL/IL housekeeping	(331,065)	3	3
4	AL/IL laundry	(43,619)	4	4
5	AL/IL heat & other utilities	(395,250)	5	5
6	AL/IL maintenance	(907,038)	6	6
7	AL/IL nursing costs	(929,169)	10	7
8	AL/IL activities	(339,342)	11	8
9	AL/IL Social Services	(53,721)	12	9
10	AL/IL Dues, fees, subs	(1,742)	20	10
11	AL/IL office & clerical	(43,676)	21	11
12	Miscellaneous income	(16,747)	21	12
13	Medication Setup income	(41,353)	21	13
14	AL/IL nursing & admissions emp benefits	(111,680)	22	14
15	AL/IL travel & seminar	-	24	15
16	AL/IL insurance	(213,095)	26	16
17	AL/IL depreciation	(2,425,274)	30	17
18	AL/IL bond interest	(351,417)	32	18
19	AL/IL equipment rent	(27,917)	35	19
20	Beauty shop income	-	40	20
21	Maintenance late Fees	(3)	6	21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,395,279)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Crossing# 0046698

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

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	(1,332,374)	0	0	0	0	0	0	0	0	0	0	(1,332,374)	1
2	Food Purchase	(920,946)	2,635	0	0	0	0	0	0	0	0	0	(918,311)	2
3	Housekeeping	(339,753)	0	0	0	0	0	0	0	0	0	0	(339,753)	3
4	Laundry	(43,619)	0	0	0	0	0	0	0	0	0	0	(43,619)	4
5	Heat and Other Utilities	(395,250)	0	0	0	0	0	0	0	0	0	0	(395,250)	5
6	Maintenance	(907,525)	0	0	0	0	0	0	0	0	0	0	(907,525)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,939,466)	2,635	0	(3,936,831)	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	(929,169)	0	0	0	0	0	0	0	0	0	0	(929,169)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(349,288)	0	0	0	0	0	0	0	0	0	0	(349,288)	11
12	Social Services	(53,721)	0	0	0	0	0	0	0	0	0	0	(53,721)	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	(1,332,178)	0	0	0	0	0	0	0	0	0	0	(1,332,178)	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	11,343	0	0	0	0	0	0	0	0	0	11,343	19
20	Fees, Subscriptions & Promotions	(1,742)	0	0	0	0	0	0	0	0	0	0	(1,742)	20
21	Clerical & General Office Expenses	(1,097,793)	(273,069)	0	0	0	0	0	0	0	0	0	(1,370,862)	21
22	Employee Benefits & Payroll Taxes	(111,680)	354,040	0	0	0	0	0	0	0	0	0	242,360	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	34,957	0	0	0	0	0	0	0	0	0	34,957	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(213,095)	20,628	0	0	0	0	0	0	0	0	0	(192,467)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,424,310)	147,899	0	(1,276,411)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,695,954)	150,534	0	(6,545,420)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

07/01/2017 Ending:

06/30/2018

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,425,274)	40,717	0	0	0	0	0	0	0	0	0	(2,384,557)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(351,417)	0	0	0	0	0	0	0	0	0	0	(351,417)	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	(27,917)	0	0	0	0	0	0	0	0	0	0	(27,917)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,804,608)	40,717	0	(2,763,891)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(897,114)	0	0	0	0	0	0	0	0	0	0	(897,114)	43
44	TOTAL Special Cost Centers	(897,114)	0	0	0	0	0	0	0	0	0	0	(897,114)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,397,675)	191,251	0	(10,206,424)	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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	2 <u>Food Purchases</u>	\$	<u>Smith Senior Living</u>		\$ 2,635	\$ 2,635	1
2	V	19 <u>Professional Services</u>		<u>Smith Senior Living</u>		11,343	11,343	2
3	V	21 <u>Clerical & General Office Exp</u>		<u>Smith Senior Living</u>		1,095,650	1,095,650	3
4	V	22 <u>PR Taxes & Employee Benefits</u>		<u>Smith Senior Living</u>		354,040	354,040	4
5	V	24 <u>Travel and Seminar</u>		<u>Smith Senior Living</u>		34,957	34,957	5
6	V	26 <u>Insurance</u>		<u>Smith Senior Living</u>		20,628	20,628	6
7	V	30 <u>Depreciation</u>		<u>Smith Senior Living</u>		40,717	40,717	7
8	V							8
9	V							9
10	V							10
11	V	21 <u>Management Fees</u>	1,368,719				(1,368,719)	11
12	V							12
13	V							13
14	Total		\$ 1,368,719			\$ 1,559,970	\$ * 191,251	14

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

Facility Name & ID Number

Smith Crossing

0046698

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Andrew J. Anello							1
2	Thomas E. Chomicz							2
3	John E. Leahy							3
4	Judith K. Lewis							4
5	George E. Petraitis							5
6	Timothy Regan							6
7	Kay E. Thurn							7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number

Smith Crossing

0046698

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

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	Andrew J. Anello	Chair							\$		1
2	Thomas E. Chomicz	Vice Chair									2
3	John E. Leahy	Trustee									3
4	Judith K. Lewis	Trustee									4
5	George E. Petraitis	Trustee									5
6	Timothy Regan	Trustee									6
7	Kay E. Thurn	Ex-Officio									7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

07/01/2017

Ending: 6/30/2018

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

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

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

1	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	40,118,905	2	\$ 5,687	\$ 18,588,758	\$ 2,635	1
2	19	Professional Serivces	Direct Costs	40,118,905	2	24,481	18,588,758	11,343	2
3	21	Clerical & General Office Exp	Direct Costs	40,118,905	2	2,364,671	1,621,073	1,095,650	3
4	22	PR Taxes & Employee Benefits	Direct Costs	40,118,905	2	764,101	18,588,758	354,040	4
5	24	Travel and Seminar	Direct Costs	40,118,905	2	75,445	18,588,758	34,957	5
6	26	Insurance	Direct Costs	40,118,905	2	44,519	18,588,758	20,628	6
7	30	Depreciation	Direct Costs	40,118,905	2	87,876	18,588,758	40,717	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 3,366,780	\$ 1,621,073	\$ 1,559,970	25

Facility Name & ID Number

Smith Crossing

0046698

Report Period Beginning:

07/01/2017

Ending:

06/30/2018

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		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 2013A		X	Construction/Refinance	N/A	11/8/2013	\$ 23,600,000	\$ 19,203,520	11/15/2038	Variable	\$ 781,073	1						
2	Bond - Series 2013B		X	Construction/Refinance	N/A	11/8/2013	16,400,000	13,344,708	11/15/2038	Variable	543,000	2						
3												3						
4												4						
5												5						
Working Capital																		
6	Proven Business Systems		X	Copier Lease	\$410.00	6/11/2014	21,561		6/11/2019	7.0000	578	6						
7												7						
8												8						
9	TOTAL Facility Related				\$410.00		\$ 40,021,561	\$ 32,548,228			\$ 1,324,651	9						
B. Non-Facility Related*																		
10												10						
11												11						
12	Debt Issuance Costs										57,140	12						
13	See Supplemental Schedule										(351,417)	13						
14	TOTAL Non-Facility Related						\$	\$			\$ (294,277)	14						
15	TOTALS (line 9+line14)						\$ 40,021,561	\$ 32,548,228			\$ 1,030,374	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 2017 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 2018 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:

2013	<u> </u>	8
2014	<u> </u>	9
2015	<u> </u>	10
2016	<u> </u>	11
2017	<u> </u>	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2017	\$ <u> </u>	13
14	PLUS APPEAL COST FROM LINE 5	\$ <u> </u>	14
15	LESS REFUND FROM LINE 6	\$ <u> </u>	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ <u> </u>	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Smith Crossing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046698

CONTACT PERSON REGARDING THIS REPORT Raymond Marneris

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

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

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

07/01/2017 Ending:

06/30/2018

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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 - 276,788 square feet - 97 units

Smith Crossing, Assisted Living - 50,432 square feet, 48 units

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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		<u>1,306,800</u>	<u>2001</u>	<u>\$ 6,452,639</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>1,306,800</u>		<u>\$ 6,452,639</u>	<u>3</u>

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	\$	\$	\$
5	16			2012	7,235,761		20			
6										
7										
8										
	Improvement Type**									
9	Various			2005	351		10			
10	Various			2006	2,307		10			
11	Various			2007	3,735		10			
12	Various			2008	27,212		10			
13	Various			2009	85,261		10			
14	Various			2010	40,467		10			
15	Various			2011	58,802		10			
16	Various			2012	553,868		10			
17	Various			2013	28,027,806		15			
18	Courtyard Lighting			2014	5,265		15			
19	Construction Adjustment			2014	8,957		15			
20	IT Suite			2014	285,631		15			
21	Salon/Spa			2015	16,407		5			
22	New Entrance Door			2015	12,956		5			
23	Concrete Pier			2015	6,945		5			
24	Deposit for addition of four seasons room to Villa 10408			2015	10,000		10			
25	Remaining payment for four seasons room addition to Villa 10408			2015	15,286		10			
26	Repairs to Asphalt			2015	8,923		5			
27	Villa 10410 Window Upgrades			2015	7,012		10			
28	Villa Driveway Repairs			2016	42,265		10			
29	Swing gate/Black Handrails w/posts			2015	3,550		10			
30	Walk-in Freezer and ramp			2015	21,403		10			
31	Apt 2307 Upgrades - custom cabinets, carpeting, painting			2015	20,504		10			
32	Window tinting - AL Corridor/Dining Room			2015	5,800		10			
33	Drain tile system repairs			2016	3,100		10			
34	Garage Doors - Villas 10430-10432			2016	4,590		10			
35	Security System			2016	11,610		5			
36	LED Lighting Project - IL building, garage and IL dining area			2016	37,201		5			

*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

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	Roof Access Repairs	2016	\$ 10,575	\$	5	\$	\$	\$	37
38	Unit 1203 IL Upgrades, carpeting and hardwood floors	2016	10,243		10				38
39	Heating Updates, AL dining, common and laundry areas	2016	42,439		10				39
40	Unit 1307 IL Upgrades, custom cabinets	2016	12,383		10				40
41	Dietary Panels	2016	5,402		10				41
42	Unit 2118 IL Upgrades, custom cabinets	2016	13,367		10				42
43	Unit Upgrades, custom cabinets, painting, carpeting and hardwood	2016	212,019		10				43
44	Wall Safes	2016	21,625		10				44
45	Telephone System	2016	102,915		10				45
46	Heating Unit #7	2017	15,710		10				46
47	Conference room #2205, 1104	2018	5,045		5				47
48	Skilled Spa Upgrades	2018	30,277		10				48
49	Skilled Common area upgrades	2018	22,448		5				49
50	Heating/Air System - Skilled	2018	6,284		15				50
51									51
52	Less AL/IL, non-care fixed assets		(55,942,037)						52
53									53
54	Total Building & Building Improvements Depreciation Expense			3,067,622		3,067,622		23,859,631	54
55	Less: AL/IL Depreciation			(2,251,021)		(2,251,021)		(17,508,197)	55
56	Add: Home Office Allocation			40,717		40,717			56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 20,358,099	\$ 857,318		\$ 857,318	\$	\$ 6,351,434	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:

07/01/2017

Ending:

06/30/2018

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,805,309	\$ 231,618	\$ 231,618	\$	Various	\$ 1,599,487	71
72	Current Year Purchases	192,795	4,246	4,246			4,246	72
73	Fully Depreciated Assets							73
74	Less AL/IL	(141,473)	(174,251)	(174,251)			(1,173,704)	74
75	TOTALS	\$ 2,856,631	\$ 61,613	\$ 61,613	\$		\$ 430,029	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attached			\$ 202,788	\$ 1,650	\$ 1,650	\$	Various	\$ 168,438	76
77										77
78										78
79										79
80	TOTALS			\$ 202,788	\$ 1,650	\$ 1,650	\$		\$ 168,438	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)	\$ 29,870,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 920,581	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 920,581	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)	\$ 6,949,901	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	AL/IL, Building, Equipment	\$ 56,083,510	\$ 2,425,274	\$ 18,681,901	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 56,083,510	\$ 2,425,274	\$ 18,681,901	91

G. Construction-in-Progress

	Description	Cost	
92	Unit Upgrades	\$ 12,134	92
93	Rehab Expansion - Design	1,008,823	93
94	Upgrade IL Interiors	7,598	94
95		\$ 1,028,555	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning: 07/01/2017

Ending: 06/30/2018

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 38,045 Description: O2 Contretrator Rentals/Kitchen Equipment

(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.

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			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A-3	hrs	\$	3,344	\$ 216,666	\$ 1,583	3,344	\$ 218,249	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,230	84,094		1,230	84,094	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3, 39-2	hrs		3,689	263,210	3,151	3,689	266,361	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescripts				211,446		211,446	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Billable Supplies</u>	39-3					73,622		73,622	12
13	Other (specify): <u>Xray/Lab</u>	39-3					29,727		29,727	13
14	TOTAL			\$	8,263	\$ 563,970	\$ 319,529	8,263	\$ 883,499	14

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

Facility Name & ID Number **Smith Crossing**# **0046698**Report Period Beginning: **07/01/2017**Ending: **06/30/2018****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **06/30/2018**

(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	\$ 2,650,706	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>97,701</u>)	1,740,053		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	92,857		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,483,616	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	13,542,249		12
13	Land	6,452,639		13
14	Buildings, at Historical Cost	77,684,105		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,833,754		16
17	Accumulated Depreciation (book methods)	(25,631,802)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Cost of Acquiring</u>	493,873		22
23	Other(specify): <u>Construction in Progress</u>	1,028,555		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 76,403,373	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 80,886,989	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,191,693	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	248,012		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Supplemental Schedule</u>	811,745		36
37	<u>Current Portion of Long-Term Debt</u>	1,044,737		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 5,296,187	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	31,193,982		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Supplemental Schedule</u>	48,391,459		43
44	<u>Interest Rate Swap Agreement</u>	381,284		44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 79,966,725	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 85,262,912	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,375,923)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 80,886,989	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,169,305)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,169,305)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	793,386	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) rounding	(4)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 793,382	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)	\$ (4,375,923)	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	\$ 17,021,662	1
2	Discounts and Allowances for all Levels	(1,581,747)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 15,439,915	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,161,974	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,161,974	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	143,303	13
14	Non-Patient Meals	90,147	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,688	16
17	Sale of Drugs	203,863	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	61,543	19
20	Radiology and X-Ray	15,664	20
21	Other Medical Services	233,828	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 757,036	23
D. Non-Operating Revenue			
24	Contributions	19,461	24
25	Interest and Other Investment Income***	1,935,255	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,954,716	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	68,530	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 68,530	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,382,171	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	4,848,742	31
32	Health Care	4,091,946	32
33	General Administration	3,542,675	33
B. Capital Expense			
34	Ownership	4,724,974	34
C. Ancillary Expense			
35	Special Cost Centers	1,355,263	35
36	Provider Participation Fee	25,185	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 18,588,785	40
41	Income before Income Taxes (line 30 minus line 40)**	793,386	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 793,386	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 81,901	44
45	Private Pay - Net Inpatient Revenue	14,325,828	45
46	Medicare - Net Inpatient Revenue	1,008,317	46
47	Other-(specify)	23,869	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 15,439,915	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.

Facility Name & ID Number **Smith Crossing**

0046698

Report Period Beginning: **07/01/2017**

Ending: **06/30/2018**

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	1,834	1,995	\$ 99,014	\$ 49.63	1
2	Assistant Director of Nursing	1,755	1,995	73,970	37.08	2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	38,409	41,338	564,591	13.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,660	1,660	34,284	20.65	9
10	Activity Assistants	14,391	16,726	260,793	15.59	10
11	Social Service Workers	1,674	1,955	66,317	33.92	11
12	Dietician					12
13	Food Service Supervisor	1,761	1,927	22,099	11.47	13
14	Head Cook	3,210	3,512	59,476	16.94	14
15	Cook Helpers/Assistants	68,707	72,841	838,083	11.51	15
16	Dishwashers					16
17	Maintenance Workers	18,991	20,512	372,740	18.17	17
18	Housekeepers	30,327	33,338	403,120	12.09	18
19	Laundry	3,462	3,879	44,230	11.40	19
20	Administrator	1,740	1,988	147,111	74.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,166	9,867	126,781	12.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,848	2,083	30,902	14.84	31
32	Other Health Care(specify)	5,359	5,904	163,418	27.68	32
33	Other(specify)	33,124	36,989	517,123	13.98	33
34	TOTAL (lines 1 - 33)	237,418	258,509	\$ 3,824,052 *	\$ 14.79	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	\$ 517,733	1-3	35
36	Medical Director	15,000	9-3	36
37	Medical Records Consultant	1,600	10-3	37
38	Nurse Consultant	44,547	10-3	38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	321	11-3	44
45	Social Service Consultant	975	12-3	45
46	Other(specify) <u>Marketing</u>	75,921	43-3	46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 656,097		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	23,704	\$ 1,074,701	10-3	50
51	Licensed Practical Nurses	17,038	569,806	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	40,742	\$ 1,644,507		53

Invoice Date	Firm Name	Allowable Amt	Non- Allow Amt	Description of Services
8/10/2017	Quarles & Brady, LLC	1,559.00	0	General corporate advice
8/17/2017	Polsinelli Shughart	892.50	0	General corporate advice
9/12/2017	Quarles & Brady, LLC	943.00	0	General corporate advice
10/10/2017	Polsinelli Shughart	480.00	0	Construction discussions
11/16/2017	Polsinelli Shughart	275.00	0	General corporate advice
3/28/2018	Benesch Friedlander Coplan	13,956.00	0	CON regulatory guidance
4/9/2018	John Anderson	7,065.00	0	Construction discussions
3/15/2018	Klein, Thorpe & Jenkins, LTD	349.00	0	Construction discussions
4/19/2018	Polsinelli Shughart	660.00	0	General corporate advice
4/19/2018	Polsinelli Shughart	165.00	0	General corporate advice
4/25/2018	Benesch Friedlander Coplan	889.50	0	CON regulatory guidance
4/25/2018	Benesch Friedlander Coplan	142.50	0	CON regulatory guidance
4/25/2018	Village of Orland Park	322.50	0	General legal service
5/21/2018	Benesch Friedlander Coplan	1,205.00	0	CON regulatory guidance
6/16/2018	Polsinelli Shughart	1,054.50	0	General legal service
		29,958.50		

Facility Name & ID Number Smith Crossing# 0046698Report Period Beginning: 07/01/2017Ending: 06/30/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Leading Age - \$17,580
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,528 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 25,185
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 46,617 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 90,147
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees