

		FOR BHF USE					

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0046698

Facility Name: Smith Crossing

Address: 10501 Emilie Orland Park 60467
Number City Zip Code

County: Will

Telephone Number: (708) 326-2300 Fax # (708) 326-2770

HFS ID Number:

Date of Initial License for Current Owners: 10/18/2005

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Raymond Marneris, CFO Telephone Number: (773) 747-7350
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2019 to 06/30/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Raymond Marneris
(Title) CFO

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) Deborah Emerson
Principal
(Firm Name & Address) CliftonLarsonAllen LLP
9365 Counselors Row, Suite 200, Indianapolis, IN 46240
(Telephone) (317) 569-6230 Fax # (317) 574-9707

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Smith Crossing

0046698 Report Period Beginning: 07/01/2019 Ending: 06/30/2020

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

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

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

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

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

N/A

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

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

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 3,277

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 06/30/2020 Fiscal Year: 06/30/2020
* All facilities other than governmental must report on the accrual basis.

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

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

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

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Smith Crossing

#0046698

Report Period Beginning:

07/01/2019

Ending:

06/30/2020

V. COST CENTER EXPENSES (continued)

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

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

Schedule V - Cost Center Expenses/Reclassifications - Supplemental Schedule

To Line

From Line

Reclassify administrator wages

\$ 177,607

17

21

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(105,834)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(13,728)	3		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(769,272)	21		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(202)	6		16
17	Non-Care Related Fees	(5,658)	11		17
18	Fines and Penalties	(268)	21		18
19	Entertainment	(1,437)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	19,833	21		24
25	Fund Raising, Advertising and Promotional	(669,394)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,410,453)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,956,413)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	100,889		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 100,889		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (9,855,524)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Smith Crossing# 0046698

Report Period Beginning:

07/01/2019

Ending:

06/30/2020**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	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	(1,370,705)	0	0	0	0	0	0	0	0	0	0	(1,370,705)	1
2	Food Purchase	(852,335)	2,449	0	0	0	0	0	0	0	0	0	(849,886)	2
3	Housekeeping	(360,349)	0	0	0	0	0	0	0	0	0	0	(360,349)	3
4	Laundry	(56,481)	0	0	0	0	0	0	0	0	0	0	(56,481)	4
5	Heat and Other Utilities	(353,718)	0	0	0	0	0	0	0	0	0	0	(353,718)	5
6	Maintenance	(996,915)	0	0	0	0	0	0	0	0	0	0	(996,915)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,990,503)	2,449	0	0	0	0	0	0	0	0	0	(3,988,054)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,061,327)	0	0	0	0	0	0	0	0	0	0	(1,061,327)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(252,810)	0	0	0	0	0	0	0	0	0	0	(252,810)	11
12	Social Services	(46,455)	0	0	0	0	0	0	0	0	0	0	(46,455)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,360,591)	0	0	0	0	0	0	0	0	0	0	(1,360,591)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	23,824	0	0	0	0	0	0	0	0	0	23,824	19
20	Fees, Subscriptions & Promotions	(1,985)	0	0	0	0	0	0	0	0	0	0	(1,985)	20
21	Clerical & General Office Expenses	(1,134,290)	(389,450)	0	0	0	0	0	0	0	0	0	(1,523,740)	21
22	Employee Benefits & Payroll Taxes	(112,708)	395,975	0	0	0	0	0	0	0	0	0	283,267	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(5,810)	23,745	0	0	0	0	0	0	0	0	0	17,935	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(241,789)	27,329	0	0	0	0	0	0	0	0	0	(214,460)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,496,582)	81,423	0	0	0	0	0	0	0	0	0	(1,415,159)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,847,677)	83,872	0	0	0	0	0	0	0	0	0	(6,763,805)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	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	(2,092,684)	17,017	0	0	0	0	0	0	0	0	0	(2,075,667)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(318,753)	0	0	0	0	0	0	0	0	0	0	(318,753)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(32,279)	0	0	0	0	0	0	0	0	0	0	(32,279)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,443,716)	17,017	0	0	0	0	0	0	0	0	0	(2,426,699)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(669,394)	0	0	0	0	0	0	0	0	0	0	(669,394)	43
44	TOTAL Special Cost Centers	(669,394)	0	0	0	0	0	0	0	0	0	0	(669,394)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(9,960,786)	100,889	0	0	0	0	0	0	0	0	0	(9,859,897)	45

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:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	<u>Food Purchases</u>	\$	<u>Smith Senior Living</u>		\$ <u>2,449</u>	\$ <u>2,449</u>	1
2	V	19	<u>Professional Serivces</u>		<u>Smith Senior Living</u>		<u>23,824</u>	<u>23,824</u>	2
3	V	21	<u>Clerical & General Office Exp</u>		<u>Smith Senior Living</u>		<u>1,327,362</u>	<u>1,327,362</u>	3
4	V	22	<u>PR Taxes & Employee Benefits</u>		<u>Smith Senior Living</u>		<u>395,975</u>	<u>395,975</u>	4
5	V	24	<u>Travel and Seminar</u>		<u>Smith Senior Living</u>		<u>23,745</u>	<u>23,745</u>	5
6	V	26	<u>Insurance</u>		<u>Smith Senior Living</u>		<u>27,329</u>	<u>27,329</u>	6
7	V	30	<u>Depreciation</u>		<u>Smith Senior Living</u>		<u>17,017</u>	<u>17,017</u>	7
8	V								8
9	V								9
10	V								10
11	V	21	<u>Management Fees</u>	<u>1,716,812</u>				<u>(1,716,812)</u>	11
12	V								12
13	V								13
14	Total			\$ <u>1,716,812</u>			\$ <u>1,817,701</u>	\$ * <u>100,889</u>	14

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

VII. RELATED PARTIES

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 07/01/2019 Ending: 6/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ 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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food Purchases	Direct Costs	42,495,779	2	\$ 5,125	\$	20,302,784	\$ 2,449	1
2	19	Professional Serivces	Direct Costs	42,495,779	2	49,865		20,302,784	23,824	2
3	21	Clerical & General Office Exp	Direct Costs	42,495,779	2	2,778,303		20,302,784	1,327,362	3
4	22	PR Taxes & Employee Benefits	Direct Costs	42,495,779	2	828,815		20,302,784	395,975	4
5	24	Travel and Seminar	Direct Costs	42,495,779	2	49,701		20,302,784	23,745	5
6	26	Insurance	Direct Costs	42,495,779	2	57,203		20,302,784	27,329	6
7	30	Depreciation	Direct Costs	42,495,779	2	35,619		20,302,784	17,017	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 3,804,631	\$		\$ 1,817,701	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Series 2018A Bond		X	Refinance	N/A	10/10/18	\$ 24,500,000	\$ 21,250,086	10/1/2043	Variable	\$	1	
2	Series 2018B Bond		X	Refinance	N/A	10/10/18	18,064,000	17,433,000	10/1/2043	Variable		695,893	2
3	Series 2018C Bond		X	Refinance	N/A	10/10/18	14,686,000	14,173,000	10/1/2043	Variable		557,700	3
4													4
5													5
	Working Capital												
6	Proven Business Systems		X	Copier Lease	\$410.00	6/11/14	21,561					14	6
7													7
8													8
9	TOTAL Facility Related				\$410.00		\$ 57,271,561	\$ 52,856,086			\$ 1,253,607	9	
	B. Non-Facility Related*												
10													10
11													11
12	Debt Issuance Costs											37,695	12
13	AL/IL Bond Interest											(318,753)	13
14	TOTAL Non-Facility Related						\$	\$			\$ (281,058)	14	
15	TOTALS (line 9+line14)						\$ 57,271,561	\$ 52,856,086			\$ 972,549	15	

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

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

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

FACILITY NAME Smith Crossing COUNTY Will

FACILITY IDPH LICENSE NUMBER 0046698

CONTACT PERSON REGARDING THIS REPORT Raymond Marneris

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 208,677

B. General Construction Type: Exterior Brick/SidingFrame MasonryNumber 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		1,306,800	2001	\$ 6,452,639	1
2					2
3	TOTALS	1,306,800		\$ 6,452,639	3

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

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

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

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

1	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 upgrades; base, shoe, desks, cabinet	2018	5,045		5				47
48	Skilled Spa Upgrades; demo old vanity tops, install cleats, drywall,								48
49	tile, spa floor	2018	30,277		10				49
50	Skilled Common area upgrades; tables, chairs, renovation	2018	22,448		5				50
51	Heating/Air System - Skilled	2018	6,284		15				51
52	Replace Heating Unit - SNF	2019	6,284		20				52
53	Replace Heating Unit - TCU	2019	6,284		20				53
54									54
55									55
56	Less AL/IL, non-care fixed assets		(46,549,752)						56
57									57
58	Total Building & Building Improvements Depreciation Expense			3,201,046		3,201,046		30,064,944	58
59	Less: AL/IL Depreciation			(1,954,559)		(1,954,559)		(18,357,655)	59
60	Add: Home Office Allocation			17,017		17,017			60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 29,762,953	\$ 1,263,504		\$ 1,263,504	\$	\$ 11,707,289	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 2,630,968	\$ 222,598	\$ 222,598	\$		\$ 1,372,357	71
72	Current Year Purchases	148,463						72
73	Fully Depreciated Assets							73
74		(90,652)	(138,124)	(138,124)			(837,961)	74
75	TOTALS	\$ 2,688,779	\$ 84,474	\$ 84,474	\$		\$ 534,396	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attached			\$ 202,788	\$ 3,600	\$ 3,600	\$	10	\$ 175,638	76
77										77
78										78
79										79
80	TOTALS			\$ 202,788	\$ 3,600	\$ 3,600	\$		\$ 175,638	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 39,107,159	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,351,578	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 1,351,578	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 12,417,323	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	CIP - Phase 3	\$ 20,754,289	92
93			93
94			94
95		\$ 20,754,289	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☒ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

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

C. Vehicle Rental (See instructions.)

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

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

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	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-3,2	hrs	\$	3,911	\$ 212,565	\$ 401	3,911	\$ 212,966	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		1,370	88,282		1,370	88,282	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3, 39-2	hrs		5,883	341,946	116	5,883	342,062	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				211,233		211,233	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): <u>Billable Supplies</u>	39-3					84,692		84,692	12
13	Other (specify): <u>X-Ray/Lab/Other</u>	39-3					48,304		48,304	13
14	TOTAL			\$	11,164	\$ 642,793	\$ 344,746	11,164	\$ 987,539	14

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

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	\$ 4,183,021	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,353)	2,510,432		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,176		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,761,629	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	17,151,821		12
13	Land	6,452,639		13
14	Buildings, at Historical Cost	80,486,847		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,461,285		16
17	Accumulated Depreciation (book methods)	(31,612,939)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in Progress	20,754,289		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 95,693,942	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 102,455,571	\$	25

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (10,682,830)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (10,682,830)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,279,266)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (6,279,264)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (16,962,094)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning: 07/01/2019

Ending: 06/30/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 18,485,691	1
2	Discounts and Allowances for all Levels	(1,462,155)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 17,023,536	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,246,800	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,246,800	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	113,024	13
14	Non-Patient Meals	105,834	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	13,728	16
17	Sale of Drugs	204,279	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	38,106	19
20	Radiology and X-Ray	11,562	20
21	Other Medical Services	168,549	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 655,082	23
	D. Non-Operating Revenue		
24	Contributions	8,349	24
25	Interest and Other Investment Income***	128,053	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 136,402	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule</u>	364,496	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 364,496	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 19,426,316	30

2

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

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

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

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

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

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

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 575,876	01-3	35
36	Medical Director				36
37	Medical Records Consultant		15,000	09-3	37
38	Nurse Consultant		1,200	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		1,788	11-3	44
45	Social Service Consultant		1,602	12-3	45
46	Other(specify) <u>Marketing Consultant</u>		162,853	43-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 758,319		49

C. CONTRACT NURSES

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

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Leading Age - \$17,925
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,647 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 25,254
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 41,649 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 105,834
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.