

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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 EmilieOrland Park60467
NumberCityZip Code

County: Will

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

HFS ID Number:

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

Type of Ownership:

X

VOLUNTARY,NON-PROFIT

X

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: Ema Araiza, ControllerTelephone Number: 773-474-7344
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 7/01/2024 to 6/30/2025 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)

(Type or Print Name) Raymond Marneris

(Title) CFO

Paid Preparer

(Signed)

(Print Name and Title) Matthew LarshSigning Director

(Firm Name & Address) CLA - CliftonLarsonAllen LLP833 West Lincoln Highway, Suite 210W, Schererville, IN 463

(Telephone) 630-368-3666Fax # 219-864-0055

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406
Phone # (217) 782-1630

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/01/2024 Ending: 6/30/2025

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>92</u>	Skilled (SNF)	<u>92</u>	<u>33,580</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>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	639				14,293	10,038	2,708	27,678	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	639				14,293	10,038	2,708	27,678	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 82.42%

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 certified beds.
number of certified beds 92

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 6/30/2025 Fiscal Year: 6/30/2025

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

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	1,584,776	197,558	1,037,953	2,820,287		2,820,287	(1,818,665)	1,001,622			1
2	Food Purchase		1,484,587		1,484,587		1,484,587	(1,206,550)	278,037			2
3	Housekeeping	718,957	57,051	9,287	785,295		785,295	(423,280)	362,015			3
4	Laundry	20,759	22,773	15,272	58,804		58,804		58,804			4
5	Heat and Other Utilities			755,363	755,363		755,363	(621,475)	133,888			5
6	Maintenance	507,631	64,785	1,239,710	1,812,126		1,812,126	(1,495,778)	316,348			6
7	Other (specify):*											7
8	TOTAL General Services	2,832,123	1,826,754	3,057,585	7,716,462		7,716,462	(5,565,748)	2,150,714			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	2,292,275	212,548	4,221,170	6,725,993		6,725,993	(1,830)	6,724,163			10
10a	Therapy			1,525,712	1,525,712		1,525,712		1,525,712			10a
11	Activities	253,888	5,731	113,622	373,241		373,241	(2,548)	370,693			11
12	Social Services	133,623	296	2,268	136,187		136,187	(68,094)	68,093			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,679,786	218,575	5,879,272	8,777,633		8,777,633	(72,472)	8,705,161			16
	C. General Administration											
17	Administrative	141,156			141,156		141,156		141,156			17
18	Directors Fees											18
19	Professional Services			141,577	141,577		141,577	43,275	184,852			19
20	Dues, Fees, Subscriptions & Promotions			104,308	104,308	6,829	111,137		111,137			20
21	Clerical & General Office Expenses	592,385	42,678	2,784,141	3,419,204	(6,829)	3,412,375	(1,387,929)	2,024,446			21
22	Employee Benefits & Payroll Taxes			1,505,033	1,505,033		1,505,033	560,950	2,065,983			22
23	Inservice Training & Education			1,984	1,984		1,984		1,984			23
24	Travel and Seminar			6,374	6,374		6,374	10,696	17,070			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			708,390	708,390		708,390	(538,530)	169,860			26
27	Other (specify):* Marketing	176,835	2,183	455,492	634,510		634,510	(634,510)				27
28	TOTAL General Administration	910,376	44,861	5,707,299	6,662,536		6,662,536	(1,946,048)	4,716,488			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,422,285	2,090,190	14,644,156	23,156,631		23,156,631	(7,584,268)	15,572,363			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			1,940,166	1,940,166		1,940,166	(827,143)	1,113,023			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,202,531	2,202,531		2,202,531	(1,960,525)	242,006			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			97,360	97,360		97,360	(69,968)	27,392			35
36	Other (specify):*											36
37	TOTAL Ownership			4,240,057	4,240,057		4,240,057	(2,857,636)	1,382,421			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		238	773,485	773,723		773,723		773,723			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			142,040	142,040		142,040		142,040			42
43	Other (specify):* AL/IL	758,513	(390)	3,280,821	4,038,944		4,038,944	(4,038,944)				43
44	TOTAL Special Cost Centers	758,513	(152)	4,196,346	4,954,707		4,954,707	(4,038,944)	915,763			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	7,180,798	2,090,038	23,080,559	32,351,395		32,351,395	(14,480,848)	17,870,547			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.)

	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	(219,290)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(11,562)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(32,535)	30		9
10	Interest and Other Investment Income	(837,189)	32		10
11	Discounts, Allowances, Rebates & Refunds	(10,118)	1		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(4,850)	6		17
18	Fines and Penalties	(1,830)	10		18
19	Entertainment	(2,308)	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	(12,513)	21		24
25	Fund Raising, Advertising and Promotional	(634,510)	27		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 PG5A	(12,985,452)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,752,157)		\$	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)	271,309	VII-B	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 271,309		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (14,480,848)		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			Sch. V Line	
		Amount	Reference	
1	Political Action Committee Payments	\$0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	AL/IL dietary costs	(1,808,547)	1	3
4	AL/IL food purchases	(996,084)	2	4
5	AL/IL housekeeping	(423,280)	3	5
6	AL/IL heat & other utilities	(621,475)	5	6
7	AL/IL maintenance	(1,490,928)	6	7
8	AL/IL Social Services	(68,094)	12	8
9	AL/IL office & clerical	(933,745)	21	9
10	AL/IL insurance	(582,828)	26	10
11	AL/IL depreciation	(824,045)	30	11
12	AL/IL bond interest	(1,123,336)	32	12
13	AL/IL equipment rent	(69,968)	35	13
14				14
15	Miscellaneous Revenue	(1,630)	21	15
16	Activity Revenue	(2,548)	11	16
17	AL/IL Direct Costs	(4,038,944)	43	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(12,985,452)		49

Summary A

6/30/2025

[illegible]

Summary B

6/30/2025

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Smith Village	Chicago	Smith Senior Living	Chicago	Home Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ 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	Food Purchases	\$	Smith Senior Living		\$ 8,824	\$ 8,824	1
2	V	19	Professional Serivces		Smith Senior Living		43,275	43,275	2
3	V	21	Clerical & General Office Exp		Smith Senior Living		1,954,491	1,954,491	3
4	V	22	PR Taxes & Employee Benefits		Smith Senior Living		560,950	560,950	4
5	V	24	Travel and Seminar		Smith Senior Living		13,004	13,004	5
6	V	26	Insurance		Smith Senior Living		44,298	44,298	6
7	V	30	Depreciation		Smith Senior Living		29,437	29,437	7
8	V								8
9	V								9
10	V								10
11	V	21	Management Fees	2,382,970				(2,382,970)	11
12	V								12
13	V								13
14	Total			\$ 2,382,970			\$ 2,654,279	\$ * 271,309	14

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

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	Monica Ryan	Chair							\$		1
2	Michael Huguelet	Vice Chair									2
3	Andrew J. Anello	Trustee									3
4	Thomas Barrett	Trustee									4
5	Julia Philip-Kuli	Trustee									5
6	Kevin Lane	Trustee									6
7	Carole Griffin Ruzich	Trustee									7
8	Ann Haskins	Es-Officio									8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Smith Crossing # 0046698 Report Period Beginning: 7/01/2024 Ending: 5/30/2025

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	59,861,062	2	\$ 16,372	\$	32,263,869	\$ 8,824	1
2	19	Professional Serivces	Direct Costs	59,861,062	2	80,290		32,263,869	43,275	2
3	21	Clerical & General Office Exp	Direct Costs	59,861,062	2	3,626,283		32,263,869	1,954,491	3
4	22	PR Taxes & Employee Benefits	Direct Costs	59,861,062	2	1,040,764		32,263,869	560,950	4
5	24	Travel and Seminar	Direct Costs	59,861,062	2	24,128		32,263,869	13,004	5
6	26	Insurance	Direct Costs	59,861,062	2	82,189		32,263,869	44,298	6
7	30	Depreciation	Direct Costs	59,861,062	2	54,616		32,263,869	29,437	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					\$ 4,924,642	\$		\$ 2,654,279	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 2022 Bond Issuance		X	Refinance	N/A	3/24/22	\$ 58,415,000	\$ 53,600,000		Variable	\$ 2,146,081	1
2	Series 2022 Bond Premium		X	Refinance	N/A	3/24/22	1,940,061	1,679,456		Variable		2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 60,355,061	\$ 55,279,456			\$ 2,146,081	9
	B. Non-Facility Related*											
10												10
11												11
12	Debt Issuance Costs										56,450	12
13	Nonallowable Interest										(1,960,525)	13
14	TOTAL Non-Facility Related						\$	\$			\$ (1,904,075)	14
15	TOTALS (line 9+line14)						\$ 60,355,061	\$ 55,279,456			\$ 242,006	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.)

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME	<u>Smith Crossing</u>	COUNTY	<u>Will</u>
---------------	-----------------------	--------	-------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,321 B. General Construction Type: Exterior Brick/Siding Frame Masonary 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 - 173 units
Smith Crossing, Assisted Living/Memory Support - 40,342 square feet, 46 AL & 16 MS 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. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? yes
H. Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? no
J. 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.

K. 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

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning:

7/01/2024

Ending:

6/30/2025

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	46			2005	\$ 11,034,395	\$	40	\$	\$	4
5	46			2020	20,544,252		35			5
6										6
7										7
8										8
	Improvement Type**									
9	Watchmate ID Doorpak (\$2,004)			2006	564		20			9
10	Remove and repair sidewalks (\$2,600)			2011	731		20			10
11	SC PH 2C			2011	350,458		15			11
12	2016 Improvements			2016	35,423		varies			12
13	Signage for SC Campus (\$1,000)			2017	281		5			13
14	2018 Improvements			2018	82,089		varies			14
15	2019 Improvements			2019	39,171					15
16	2020 Improvements			2020	35,252					16
17	2021 Improvements			2021	8,811		varies			17
18	Life Safety/Bartkowski (\$12,335)			2022	3,470		5			18
19										19
20	Resurfacing of Emilie Lane (\$82,420)			2024	23,185					20
21	Emilie Lane Repairs (\$147,176)			2025	41,401					21
22	IL Unit Upgrades (\$232,314)			2025	65,350					22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34	Total Building & BI Depreciation Expense					911,594		908,496	(3,098)	8,753,313
35	Add: HO Allocation					29,437			(29,437)	
36										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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,967,552	\$198,127	\$198,127	\$	Various	\$868,555	71
72	Current Year Purchases	111,986						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,079,538	\$198,127	\$198,127	\$		\$868,555	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 schedule			\$121,031	\$6,400	\$6,400	\$	Various	\$78,142	76
77										77
78										78
79										79
80	TOTALS			\$121,031	\$6,400	\$6,400	\$		\$78,142	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)	\$40,918,041	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$1,145,558	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$1,113,023	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(32,535)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$9,700,010	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	\$70,358,810	\$3,054,593	\$39,294,389	86
87	Vehicles Non-SNF	309,225	16,352	199,647	87
88	AL/IL Equip	1,685,073	150,988	1,071,907	88
89					89
90					90
91	TOTALS	\$72,353,108	\$3,221,933	\$40,565,943	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

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

15. Is Movable equipment rental included in building rental?
☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 97,360 Description: O2 Concentrators, Med Equip, Dining Equip, Other
(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.

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ 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
		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.

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	

- (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.)

		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	hrs	\$	5,735	\$ 618,882	\$	5,735	\$ 618,882	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		2,068	189,442		2,068	189,442	2
3	Licensed Recreational Therapist	10A-3	hrs			19,415			19,415	3
4	Licensed Physical Therapist	10A-3	hrs		6,866	699,973		6,866	699,973	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				653,077		653,077	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					64,164		64,164	12
13	Other (specify): <u>X-Ray/Lab/Respiratory</u>	39-3					56,244		56,244	13
14	TOTAL			\$	14,669	\$ 1,527,712	\$ 773,485	14,669	\$ 2,301,197	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	\$ 2,358,916	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 78,025)	3,569,428		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,245		6
7	Other Prepaid Expenses	(28,594)		7
8	Accounts Receivable (owners or related parties)	24,223,899		8
9	Other(specify): AR Resident Entrance Fees	538,210		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 30,697,104	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	27,918,571		12
13	Land	6,452,639		13
14	Buildings, at Historical Cost	102,623,640		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,194,866		16
17	Accumulated Depreciation (book methods)	(50,265,953)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec See Attached	2,524,516		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 93,448,279	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 124,145,383	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 4,059,871	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	723,580		30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	428,735		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	26,228,007		36
37	Current Portion of LT Debt	1,785,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 33,225,193	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	53,494,456		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	52,104,299		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 105,598,755	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 138,823,948	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (14,678,565)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 124,145,383	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (15,943,853)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (15,943,853)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,265,293	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	(5)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,265,288	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)	\$ (14,678,565)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Smith Crossing

0046698

Report Period Beginning: 7/01/2024

Ending: 6/30/2025

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	\$ 15,398,570	1
2	Discounts and Allowances for all Levels	(3,083,394)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 12,315,176	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,378,688	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,378,688	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	13,741	13
14	Non-Patient Meals	219,290	14
15	Telephone, Television and Radio	(40)	15
16	Rental of Facility Space	11,562	16
17	Sale of Drugs	629,223	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	91,248	19
20	Radiology and X-Ray	30,309	20
21	Other Medical Services	287,995	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,283,328	23
	D. Non-Operating Revenue		
24	Contributions	34,391	24
25	Interest and Other Investment Income***	3,016,123	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,050,514	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	941,654	28
28a	AL/IL Revenue	13,647,326	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 14,588,980	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 33,616,686	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	7,716,462	31
32	Health Care	8,777,633	32
33	General Administration	6,662,536	33
	B. Capital Expense		
34	Ownership	4,240,057	34
	C. Ancillary Expense		
35	Special Cost Centers	4,812,667	35
36	Provider Participation Fee	142,040	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 32,351,395	40
41	Income before Income Taxes (line 30 minus line 40)**	1,265,291	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,265,291	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 160,086.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	6,864,722.00	48
49	Medicare Part A	6,531,030.00	49
50	Other-(specify) Managed Care	1,752,065.00	50
51	Other-(specify) Ancillary C/A	-2,992,727.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 12,315,176	56

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	188	324	\$ 23,236	\$ 71.80	1
2	Assistant Director of Nursing	1,868	2,069	121,030	58.50	2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	98,541	106,828	2,447,220	22.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,286	13,775	253,888	18.43	10
11	Social Service Workers	3,765	4,147	133,622	32.22	11
12	Dietician					12
13	Food Service Supervisor	1,970	2,180	52,184	23.94	13
14	Head Cook	3,874	4,287	118,933	27.74	14
15	Cook Helpers/Assistants	63,918	67,281	1,257,441	18.69	15
16	Dishwashers	7,418	8,075	156,218	19.35	16
17	Maintenance Workers	18,474	20,641	507,631	24.59	17
18	Housekeepers	35,429	39,316	718,957	18.29	18
19	Laundry	1,106	1,262	20,759	16.45	19
20	Administrator	1,204	1,775	141,156	79.55	20
21	Assistant Administrator	1,707	1,967	63,244	32.16	21
22	Other Administrative	3,163	3,760	109,786	29.20	22
23	Office Manager					23
24	Clerical	18,670	20,262	419,356	20.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	11,644	13,219	405,800	30.70	31
32	Other Health C: MDS	1,811	1,975	53,502	27.09	32
33	Other(specify) Marketing	3,238	3,744	176,835	47.23	33
34	TOTAL (lines 1 - 33)	290,272	316,887	\$ 7,180,798 *	\$ 22.66	34

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		\$ 964,940	01-3	35
36	Medical Director		16,500	09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		4,720	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				44
45	Social Service Consultant		2,268	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 988,428		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	21,680	\$ 1,095,712	10-3	50
51	Licensed Practical Nurses	40,574	2,412,934	10-3	51
52	Certified Nurse Assistants/Aides	16,334	530,810	10-3	52
53	TOTAL (lines 50 - 52)	78,588	\$ 4,039,456		53

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

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberSmith Crossing# 0046698Report Period Beginning:7/01/2024Ending:6/30/2025Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership

Amount

Amanda Mauceri

Executive Director

\$141,156

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$141,156

B. Administrative - Other

Description

Amount

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee

Type

Amount

Hinshaw & Culbertson

Legal

\$5,225

Paylocity

Payroll Services

51,089

Illinois Finance Authority

Consulting

7,500

UST

Consulting

6,263

Fiducient

Advisory

28,442

CLA

Accounting Services

43,058

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$141,577

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$120,644

Unemployment Compensation Insurance

FICA Taxes

534,831

Employee Health Insurance

620,214

Employee Meals

68,728

Illinois Municipal Retirement Fund (IMRF)*

Disability insurance

2,488

Life insurance

1,427

Pension / 401K

86,925

PTO Used / Not Paid

45,006

Tuition

24,770

Add: Home Office employee benefits

560,950

TOTAL (agree to Schedule V, line 22, col.8)

\$2,065,983

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$6,829

Advertising: Employee Recruitment

15,322

Health Care Worker Background Check (Indicate # of checks performed)

46,617

Patient Background Checks

Association Dues (total from pg 22, #4)

32,400

Dues & Memberships

6,704

Subscriptions

3,265

Less: Public Relations Expense

()

PAC and Lobbying payments

()

All non-allowable advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$111,137

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

949

Meals and Entertainment

2,308

Seminar Expense

3,117

Add: Home Office Allocation

13,004

Less: non-allowable

(2,308)

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$17,070

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

LEADING AGE

Amount

32,400

32,400

Total

(3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

LEADING AGE

Total

(4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

LEADING AGE

32,400

32,400

Total

(5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$

51,466

Line

10-2

(6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

142,040

This amount is to be recorded on line 42 of Schedule V.

(8)

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.

(9)

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

(10)

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.

(11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

68,728

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

219,290

(12)

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

(13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name:

CLA

Yes

(14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(15)

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.

Yes

Attach invoices and a summary of services for all architect and appraisal fees.