		FOR BHF USE					

LL1

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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: 0010371

Facility Name: Jennings Terrace

Address: 275 South LaSalle Street (Number) Aurora (City) 60505 (Zip Code)

County: Kane

Telephone Number: 630.897.6946 **Fax #** 630.897.6949

HFS ID Number:

Date of Initial License for Current Owners: 07/05/1943

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code 501 (c) (3)

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/09 to 06/30/10 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) David F Scarpetta

(Title) Executive Director

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Steve Baustian

(Firm Name & Address) JMS Enterprises, PO Box 185 - Sycamore, IL 60178

(Telephone) 630.710.2121 Fax # 866.816.0699

In the event there are further questions about this report, please contact:
Name: David Scarpetta Telephone Number: 630.897.6946
Email Address:

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 Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 09/08

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	8	Skilled (SNF)	8	2,920	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5	103	Sheltered Care (SC)	103	37,595	5
6		ICF/DD 16 or Less			6
7	163	TOTALS	163	59,495	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,335	386		2,721	8
9	SNF/PED					9
10	ICF		17,108		17,108	10
11	ICF/DD					11
12	SC		29,702		29,702	12
13	DD 16 OR LESS					13
14	TOTALS	2,335	47,196		49,531	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.25%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? NO

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/15/43

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: JUNE 30 Fiscal Year: JUNE 30

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	270,216	17,995	5,599	293,810		293,810		293,810			1
2	Food Purchase		260,357		260,357	(20,634)	239,723	(9,459)	230,264			2
3	Housekeeping	48,165	30,752	29,912	108,829		108,829		108,829			3
4	Laundry	26,517	4,869		31,386		31,386		31,386			4
5	Heat and Other Utilities			131,278	131,278		131,278		131,278			5
6	Maintenance	80,484		95,032	175,516		175,516		175,516			6
7	Other (specify):*											7
8	**TOTAL General Services**	425,382	313,973	261,821	1,001,176	(20,634)	980,542	(9,459)	971,083			8
	B. Health Care and Programs											
9	Medical Director			110	110		110		110			9
10	Nursing and Medical Records	1,221,744	53,872	38,138	1,313,754		1,313,754		1,313,754			10
10a	Therapy											10a
11	Activities	112,985	4,310		117,295		117,295		117,295			11
12	Social Services	49,467	350	2,730	52,547		52,547		52,547			12
13	CNA Training											13
14	Program Transportation			7,716	7,716		7,716	(719)	6,997			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,384,196	58,532	48,694	1,491,422		1,491,422	(719)	1,490,703			16
	C. General Administration											
17	Administrative	73,400		8,000	81,400		81,400	(8,000)	73,400			17
18	Directors Fees											18
19	Professional Services			25,535	25,535		25,535		25,535			19
20	Dues, Fees, Subscriptions & Promotions			50,195	50,195		50,195	(35,769)	14,426			20
21	Clerical & General Office Expenses	72,457	6,429	29,469	108,355		108,355		108,355			21
22	Employee Benefits & Payroll Taxes			350,058	350,058	20,634	370,692		370,692			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,112	2,112		2,112		2,112			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			69,538	69,538		69,538		69,538			26
27	Other (specify):*											27
28	**TOTAL General Administration**	145,857	6,429	534,907	687,193	20,634	707,827	(43,769)	664,058			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,955,435	378,934	845,422	3,179,791		3,179,791	(53,947)	3,125,844			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 Jennings Terrace #0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			97,432	97,432		97,432		97,432			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			97,432	97,432		97,432		97,432			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			32,850	32,850		32,850		32,850			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,955,435	378,934	975,704	3,310,073		3,310,073	(53,947)	3,256,126			45

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	(9,459)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				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)	(719)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,120)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(16,649)	20		28
29	Other-Attach Schedule	(8,000)	17		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (53,947)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (53,947)		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

Jennings Terrace

ID# 0010371

Report Period Beginning: 07/01/09

Ending: 06/30/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	SPECIAL ASSESSMENT	$ (8,000)	17	1
2				2
3				3
4				4
5				5
6				6
7				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
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**	(8,000)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jennings Terrace **#** 0010371 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,459)	0	0	0	0	0	0	0	0	0	0	(9,459)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,459)	0	0	0	0	0	0	0	0	0	0	(9,459)	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	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(719)	0	0	0	0	0	0	0	0	0	0	(719)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(719)	0	0	0	0	0	0	0	0	0	0	(719)	16
	C. General Administration													
17	Administrative	(8,000)	0	0	0	0	0	0	0	0	0	0	(8,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(35,769)	0	0	0	0	0	0	0	0	0	0	(35,769)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(43,769)	0	0	0	0	0	0	0	0	0	0	(43,769)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(53,947)	0	0	0	0	0	0	0	0	0	0	(53,947)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jennings Terrace **#** 0010371 **Report Period Beginning:** 07/01/09 **Ending:** 06/30/10

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(53,947)	0	0	0	0	0	0	0	0	0	0	(53,947)	45

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
THIS SCHEDULE IS N/A						

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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	THIS SCHEDULE IS N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 [XX]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										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					$	$		$	25

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	THIS SCHEDULE IS N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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 & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

THIS SCHEDULE IS N/A

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jennings Terrace COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0010371

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,000 B. General Construction Type: Exterior BRICK Frame BLOCK Number of Stories 1

C. Does the Operating Entity? [XX] (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? [XX] (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).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [XX] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	475,904	VARIOUS	$ 574,906	1
2					2
3	TOTALS	475,904		$ 574,906	3

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	103		1961	1961	$ 603,512	$	40	$	$	$ 603,512	4
5	60		1985	1985	1,863,135	46,578	40	46,578		1,148,931	5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENT			1967	34,983		40			34,983	9
10	BUILDING IMPROVEMENT			1968	8,760		40			8,760	10
11	BUILDING IMPROVEMENT			1990	4,376	109	40	109		2,210	11
12	BUILDING IMPROVEMENT			1992	4,550		VAR			4,550	12
13	BUILDING IMPROVEMENT			1993	7,238		15			7,238	13
14	BUILDING IMPROVEMENT			1994	4,677		VAR			4,677	14
15	BUILDING IMPROVEMENT - ROOF REPAIR			1996	92,951		VAR			92,951	15
16	BUILDING IMPROVEMENT			1996	5,238		VAR			5,238	16
17	BUILDING IMPROVEMENT			1998	3,243		10			3,243	17
18	BUILDING IMPROVEMENT - RETAINING WALL			1999	8,049	322	40	322		2,609	18
19	BUILDING IMPROVEMENT - RETAINING WALL			2000	8,361	334	40	334		2,500	19
20	BUILDING IMPROVEMENT - HANDICAPPED ENTRY			2000	43,900	1,150	40	1,150		13,317	20
21	BUILDING IMPROVEMENT - RETAINING WALL			2001	8,361	334	40	334		2,465	21
22	BUILDING IMPROVEMENT - WINDOWS			2001	2,666	267	10	267		2,535	22
23	BUILDING IMPROVEMENT - KITCHEN FLOOR / WINDOWS			2002	14,456	588	VAR	588		8,989	23
24	BUILDING IMPROVEMENT - KITCHEN RENOVATION / DOOR			2003	7,541	754	VAR	754		5,069	24
25	BUILDING IMPROVEMENT - MAIN BREAKER			2005	8,900	890	10	890		4,304	25
26	BUILDING IMPROVEMENT - DOOR / HVAC IMPROVEMENTS			2005	4,150	415	10	415		2,510	26
27	BUILDING IMPROVEMENT - WATER PIPE / CARPETING			2006	7,157	1,030	VAR	1,030		5,146	27
28	BUILDING IMPROVEMENT - ROOF, WIRING, FLOORING			2007	24,900	2,490	10	2,490		9,960	28
29	BUILDING IMPROVEMENT - LOCKER ROOM REMODEL			2008	7,500	750	10	750		1,875	29
30	BUILDING IMPROVEMENT - BATHROOM REMODEL			2008	44,531	2,969	15	2,969		7,422	30
31	BUILDING IMPROVEMENT - ROOF REPAIR			2008	7,909	791	10	791		1,978	31
32	BUILDING IMPROVEMENT - ROOF REPAIR			2009	15,332	1,533	10	1,533		3,066	32
33	BUILDING IMPROVEMENT - CARPETING			2010	9,033	904	5	904		904	33
34											34
35											35
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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LAND IMP - PARKING LOT	1974	$ 470	$	7	$	$	$ 470	37
38	LAND IMP - PARKING LOT	1985	880		7			880	38
39	LAND IMP - PARKING LOT	1992	7,445		10			7,445	39
40	LAND IMP - PARKING LOT	2001	7,549	755	10	755		7,425	40
41	LAND IMP - PARKING LOT	2003	30,959	3,096	10	3,096		22,264	41
42	LAND IMP - PARKING LOT LIGHTS	2010	3,518	176	10	176		176	42
43									43
44	LAND IMP - VARIOUS	1978	2,317		10			2,317	44
45	LAND IMP - VARIOUS	1982	1,007		10			1,007	45
46	LAND IMP - VARIOUS	1988	4,084		10			4,084	46
47	LAND IMP - YARD LIGHTS	1989	1,390		15			1,390	47
48	LAND IMP - SIDEWALK	1990	1,450		10			1,450	48
49	LAND IMP - SIDEWALK	1991	600		10			600	49
50	LAND IMP - SIDEWALK	1994	440		15			440	50
51	LAND IMP - SIDEWALK	1998	1,592		10			1,592	51
52	LAND IMP - SIDEWALK	2002	225	22	10	22		128	52
53	LAND IMP - FENCE	2003	3,581	358	10	358		2,741	53
54	LAND IMP - FENCE	2004	4,353	435	10	435		2,391	54
55	LAND IMP - TREE REMOVAL / CONCRETE	2005	15,812	1,581	10	1,581		6,896	55
56	LAND IMP - TERRACE	2010	35,935	1,198	15	1,198		1,198	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,979,016	$ 69,829		$ 69,829	$	$ 2,055,836	70

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 95,445	$ 15,208	$ 15,208	$		$ 61,701	71
72	Current Year Purchases	28,451	2,697	2,697			2,697	72
73	Fully Depreciated Assets	656,368					656,368	73
74								74
75	TOTALS	$ 780,264	$ 17,905	$ 17,905	$		$ 720,766	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT / STAFF TRANS	93 FORD CLUB WAGON	1993	$ 17,333	$	$	$	7	$ 17,333	76
77	RESIDENT / STAFF TRANS	08 STARCRAFT VAN	2009	48,491	9,698	9,698		5	14,547	77
78										78
79										79
80	TOTALS			$ 65,824	$ 9,698	$ 9,698	$		$ 31,880	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)	$	4,400,010	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	97,432	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	97,432	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)	$	2,808,482	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: THIS SCHEDULE IS 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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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 [XX] 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)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): THIS SCHEDULE IS N/A									13
14	TOTAL			$		$	$		$	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.

STATE OF ILLINOIS

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,135,870	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	266,560		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,367		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)**	$ 1,426,797	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	574,906		13
14	Buildings, at Historical Cost	2,979,016		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	846,088		16
17	Accumulated Depreciation (book methods)	(2,808,482)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,591,528	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,018,325	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 61,715	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,951		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED REVENUE	131,724		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 323,390	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 323,390	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,694,935	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,018,325	$	48

***(See instructions.)**

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,242,888	1
2	Restatements (describe):		2
3	**AUDIT ADJUSTMENT - W/O ACCTS RECEIVABLE**	(13,209)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,229,679	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	465,256	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 465,256	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,694,935	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,798,723	1
2	Discounts and Allowances for all Levels	(67,213)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,731,510	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	2,696	13
14	Non-Patient Meals	9,459	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 12,155	23
	D. Non-Operating Revenue		
24	Contributions	24,083	24
25	Interest and Other Investment Income***	1,698	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,781	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS INCOME	5,883	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,883	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,775,329	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,001,176	31
32	Health Care	1,491,422	32
33	General Administration	687,193	33
	B. Capital Expense		
34	Ownership	97,432	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,310,073	40
41	**Income before Income Taxes (line 30 minus line 40)****	465,256	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 465,256	43

* **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.**

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,964	2,080	$ 54,080	$ 26.00	1
2	Assistant Director of Nursing	2,381	2,533	52,643	20.78	2
3	Registered Nurses	8,290	8,455	177,141	20.95	3
4	Licensed Practical Nurses	11,598	12,143	218,224	17.97	4
5	CNAs & Orderlies	52,647	54,696	599,824	10.97	5
6	CNA Trainees	12,867	13,665	98,322	7.20	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,297	2,469	43,906	17.78	9
10	Activity Assistants	6,767	7,289	69,079	9.48	10
11	Social Service Workers	3,010	3,218	49,467	15.37	11
12	Dietician					12
13	Food Service Supervisor	2,119	2,296	37,264	16.23	13
14	Head Cook	2,043	2,297	29,834	12.99	14
15	Cook Helpers/Assistants	22,402	23,736	203,118	8.56	15
16	Dishwashers					16
17	Maintenance Workers	5,497	5,736	80,484	14.03	17
18	Housekeepers	5,573	5,740	48,165	8.39	18
19	Laundry	3,219	3,276	26,517	8.09	19
20	Administrator	1,912	2,080	73,400	35.29	20
21	Assistant Administrator					21
22	Other Administrative	3,344	3,526	72,457	20.55	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,892	2,068	21,510	10.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,822	157,303	$ 1,955,435 *	$ 12.43	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	140	$ 5,599	Ln 1, Col 3	35
36	Medical Director	per visit	110	Ln 9, Col 3	36
37	Medical Records Consultant	12	705	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per record	379	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	per visit	2,730	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	152	$ 9,523		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	346	$ 14,908	Ln 10, Col 3	50
51	Licensed Practical Nurses	236	9,937	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	559	12,218	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	1,141	$ 37,063		53

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID SCARPETTA	EXEC DIR	NONE	$ 73,400
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 73,400

B. Administrative - Other

Description	Amount
SPECIAL ASSESSMENT PAID	$ 8,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 8,000

C. Professional Services

Vendor/Payee	Type	Amount
SIKICH GARDNER & CO LLP	AUDIT	$ 8,900
JMS ENTERPRISES	ACCCOUNTING	10,725
LAW FIRM OF DREYER, FOOTE	LEGAL	5,910
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 25,535

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,857
Unemployment Compensation Insurance	29,155
FICA Taxes	145,576
Employee Health Insurance	113,699
Employee Meals	20,634
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE INCENTIVES	6,549
TUITION REIMB	1,222
TOTAL (agree to Schedule V, line 22, col.8)	$ 370,692

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

Description	Line #	Amount
NONE		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,685
Health Care Worker Background Check	720
(Indicate # of checks performed 72)	
Patient Background Checks 53	530
DUES & SUBSCRIPTIONS	4,377
ADVERTISING	37,893
Less: Public Relations Expense	( )
Non-allowable advertising	(19,120)
Yellow page advertising	(16,649)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,426

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,112
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,112

**See instructions.

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/09 Ending: 06/30/10

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	THIS SCHEDULE IS N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NOT AVAIL** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **XX** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **XX** 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. $ **32,850**
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? **N/A**

(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. $ **20,634** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **9,459**

(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. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **WILL BE**
Firm Name: **SIKICH GARDNER LLP**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

JENNINGS TERRACE, INC **COST REPORT FOR 6/30/10**
ID: 0010371
SUPPLEMENTAL INFORMATION

OTHER REVENUE DETAIL - PAGE 19, LINE 28

OTHER MISC INCOME	5,883
TOTAL	5,883

RECLASSES - PAGE 3

COST OF EMPLOYEE MEALS RECLASSED:

FROM COL 2, LINE ------>	2	(20,634)
TO COL 3, LINE ------>	22	20,634

NURSE AIDE TRAINING - PAGE 15

NO NURSE AIDE TRAINING IS NECESSARY
BECAUSE TRAINING IS PROVIDED BY
LOCAL COMMUNITY COLLEGES

SEMINAR EXPENSES - PAGE 21

ATTENDEES	DATE	LOCATION	SEMINAR TITLE	SPONSOR	COST
DON	7/21/09	IL	HFSMPS Medicaid	LSN	179.00
OFFICE STAFF	11/17/09	IL	VOLUNTEER MANAGEMENT	CENTER FOR NON PROF	110.00
ADMINISTRATOR	12/10/09	IL	WORKPLACE WELLNESS	IL CHAMBER	129.00
ADMINISTRATOR	3/26/10	IL	MEMORY	IBP	150.00
2 NURSES	4/22/10	IL	GERIATRIC BEHAVIORS	PESI HEALTHCARE	348.00
DON	5/26 - 5/27/10	IL	MDS 3.0 TRAINING	H 1 N	399.00
2 NURSES	8/3/10	IL	PHYSICAL ASSESS SKILLS	PESI HEALTHCARE	348.00
1 NURSE	5/26 - 5/27/10	IL	MDS 3.0 TRAINING	H 1 N	399.00
VARIOUS	6/24/10	IL	PERSON CENTERED CARE	NE ILL AREA AGENCY	50.00
					2,112.00