FOR BHF USE

LL1

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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

I. IDPH License ID Number: 0010371

Facility Name: Jennings Terrace

Address: 275 South LaSalle (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
IRS Exemption Code 501 (c) (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/11 to 06/30/12 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 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

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: 07/01/11 Ending: 06/30/12

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	2,928	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	19,032	3
4		Intermediate/DD			4
5	103	Sheltered Care (SC)	103	37,698	5
6		ICF/DD 16 or Less			6
7	163	TOTALS	163	59,658	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	2,529			2,529	8
9	SNF/PED					9
10	ICF		16,756		16,756	10
11	ICF/DD					11
12	SC		25,292		25,292	12
13	DD 16 OR LESS					13
14	TOTALS	2,529	42,048		44,577	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.72%

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 03/16/43

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

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: 07/01/11 Ending: 06/30/12

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	279,977	27,502	5,664	313,143		313,143		313,143			1
2	Food Purchase		298,531		298,531	(29,120)	269,411	(18,410)	251,001			2
3	Housekeeping	44,209	29,539	20,762	94,510		94,510		94,510			3
4	Laundry	35,219	5,733		40,952		40,952		40,952			4
5	Heat and Other Utilities			113,595	113,595		113,595		113,595			5
6	Maintenance	82,173		105,482	187,655		187,655		187,655			6
7	Other (specify):*											7
8	**TOTAL General Services**	441,578	361,305	245,503	1,048,386	(29,120)	1,019,266	(18,410)	1,000,856			8
	B. Health Care and Programs											
9	Medical Director			110	110		110		110			9
10	Nursing and Medical Records	1,280,972	47,397	37,536	1,365,905		1,365,905		1,365,905			10
10a	Therapy											10a
11	Activities	131,508	3,507		135,015		135,015		135,015			11
12	Social Services	41,313		5,280	46,593		46,593		46,593			12
13	CNA Training											13
14	Program Transportation			4,579	4,579		4,579	(758)	3,821			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,453,793	50,904	47,505	1,552,202		1,552,202	(758)	1,551,444			16
	C. General Administration											
17	Administrative	84,820			84,820		84,820		84,820			17
18	Directors Fees											18
19	Professional Services			48,118	48,118		48,118		48,118			19
20	Dues, Fees, Subscriptions & Promotions			42,187	42,187		42,187	(25,965)	16,222			20
21	Clerical & General Office Expenses	88,611	7,195	30,751	126,557		126,557		126,557			21
22	Employee Benefits & Payroll Taxes			421,446	421,446	29,120	450,566		450,566			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,655	1,655		1,655		1,655			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			68,358	68,358		68,358		68,358			26
27	Other (specify):*											27
28	**TOTAL General Administration**	173,431	7,195	612,515	793,141	29,120	822,261	(25,965)	796,296			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,068,802	419,404	905,523	3,393,729		3,393,729	(45,133)	3,348,596			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:** 07/01/11 **Ending:** 06/30/12

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			117,868	117,868		117,868		117,868			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**			117,868	117,868		117,868		117,868			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			32,940	32,940		32,940		32,940			42
43	Other (specify):*			143,329	143,329		143,329		143,329			43
44	**TOTAL Special Cost Centers**			176,269	176,269		176,269		176,269			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,068,802	419,404	1,199,660	3,687,866		3,687,866	(45,133)	3,642,733			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: 07/01/11 Ending: 06/30/12

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	(18,410)	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)	(758)	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	(9,323)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(16,642)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (45,133)		$	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))**	$ (45,133)		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: 07/01/11

Ending: 06/30/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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				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**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jennings Terrace **#** 0010371 **Report Period Beginning:** 07/01/11 **Ending:** 06/30/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(18,410)	0	0	0	0	0	0	0	0	0	0	(18,410)	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**	(18,410)	0	0	0	0	0	0	0	0	0	0	(18,410)	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	(758)	0	0	0	0	0	0	0	0	0	0	(758)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(758)	0	0	0	0	0	0	0	0	0	0	(758)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(25,965)	0	0	0	0	0	0	0	0	0	0	(25,965)	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**	(25,965)	0	0	0	0	0	0	0	0	0	0	(25,965)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(45,133)	0	0	0	0	0	0	0	0	0	0	(45,133)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jennings Terrace **#** 0010371 **Report Period Beginning:** 07/01/11 **Ending:** 06/30/12

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)**	(45,133)	0	0	0	0	0	0	0	0	0	0	(45,133)	45

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

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
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: 07/01/11 Ending: 06/30/12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

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: 07/01/11 Ending: 06/30/12

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: 07/01/11 Ending: 06/30/12

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							$	$			$	1
2	THIS SCHEDULE IS N/A											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: 07/01/11 Ending: 06/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011		12

THIS SCHEDULE IS N/A

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 07/01/11 Ending: 06/30/12

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	475,304	VARIOUS	$ 574,906	1
2					2
3	TOTALS	475,304		$ 574,906	3

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		1,242,087	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		2,428	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		3,253	18
19	BUILDING IMPROVEMENT - RETAINING WALL			2000	8,361	334	40	334		3,168	19
20	BUILDING IMPROVEMENT - HANDICAPPED ENTRY			2000	43,900	1,756	40	1,756		16,829	20
21	BUILDING IMPROVEMENT - RETAINING WALL			2001	8,361	334	40	334		3,133	21
22	BUILDING IMPROVEMENT - WINDOWS			2001	2,666		10			2,666	22
23	BUILDING IMPROVEMENT - KITCHEN FLOOR / WINDOWS			2002	14,456	994	VAR	994		10,976	23
24	BUILDING IMPROVEMENT - KITCHEN RENOVATION / DOOR			2003	7,541	754	VAR	754		6,577	24
25	BUILDING IMPROVEMENT - MAIN BREAKER			2005	8,900	890	10	890		6,084	25
26	BUILDING IMPROVEMENT - DOOR / HVAC IMPROVEMENTS			2005	4,150	415	10	415		3,340	26
27	BUILDING IMPROVEMENT - WATER PIPE / CARPETING			2006	7,157	403	VAR	403		5,952	27
28	BUILDING IMPROVEMENT - ROOF, WIRING, FLOORING			2007	24,900	2,490	10	2,490		14,940	28
29	BUILDING IMPROVEMENT - LOCKER ROOM REMODEL			2008	7,500	750	10	750		3,375	29
30	BUILDING IMPROVEMENT - BATHROOM REMODEL			2008	44,531	2,969	15	2,969		13,360	30
31	BUILDING IMPROVEMENT - ROOF REPAIR			2008	7,909	791	10	791		3,560	31
32	BUILDING IMPROVEMENT - ROOF REPAIR			2009	15,332	1,533	10	1,533		6,132	32
33	BUILDING IMPROVEMENT - CARPETING			2010	9,033	1,807	5	1,807		4,518	33
34	BUILDING IMPROVEMENT - ROOF REPAIR			2011	12,943	1,294	10	1,294		1,941	34
35	BUILDING IMPROVEMENT - REMODEL SHOWERS			2011	26,801	1,787	15	1,787		2,681	35
36	BUILDING IMPROVEMENT - WALL HEATER, RAILINGS			2011	9,095	1,102	VAR	1,102		1,653	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: 07/01/11 Ending: 06/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING IMPROVEMENT - SHOWER REMODEL	2012	$ 7,900	$ 395	10	$ 395	$	$ 395	37
38	BUILDING IMPROVEMENT - CARPETING	2012	5,525	553	5	553		553	38
39	BUILDING IMPROVEMENT - NEW ROOF	2012	80,440	2,682	15	2,682		2,682	39
40	BUILDING IMPROVEMENT - EMERGENCY CIRCUITS	2012	4,985	712	7	712		712	40
41									41
42									42
43	LAND IMP - PARKING LOT	1974	470		7			470	43
44	LAND IMP - PARKING LOT	1985	880		7			880	44
45	LAND IMP - PARKING LOT	1992	7,445		10			7,445	45
46	LAND IMP - PARKING LOT - BLACKTOP	2001	7,549		10			7,549	46
47	LAND IMP - PARKING LOT - FRONT ENTRANCE	2003	30,959	3,096	10	3,096		28,456	47
48	LAND IMP - PARKING LOT - LIGHTS	2010	3,518	352	10	352		880	48
49									49
50									50
51	LAND IMP - VARIOUS	1978	2,317		10			2,317	51
52	LAND IMP - VARIOUS	1982	1,007		10			1,007	52
53	LAND IMP - VARIOUS	1988	4,084		10			4,084	53
54	LAND IMP - YARD LIGHTS	1989	1,390		15			1,390	54
55	LAND IMP - SIDEWALK	1990	1,450		10			1,450	55
56	LAND IMP - SIDEWALK	1991	600		10			600	56
57	LAND IMP - SIDEWALK	1994	440		15			440	57
58	LAND IMP - SIDEWALK	1998	1,592		10			1,592	58
59	LAND IMP - SIDEWALK	2002	225	22	10	22		172	59
60	LAND IMP - FENCE	2003	3,581	358	10	358		3,457	60
61	LAND IMP - FENCE	2004	4,353	435	10	435		3,261	61
62	LAND IMP - TREE REMOVAL / CONCRETE	2005	15,812	1,581	10	1,581		10,058	62
63	LAND IMP - TERRACE	2010	35,935	2,396	15	2,396		5,990	63
64	LAND IMP - CONCRETE WORK	2011	3,332	333	10	333		666	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,130,037	$ 80,327		$ 80,327	$	$ 2,210,311	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: 07/01/11 Ending: 06/30/12

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	$ 120,384	$ 23,946	$ 23,946	$		$ 68,620	71
72	Current Year Purchases	45,948	3,897	3,897			3,897	72
73	Fully Depreciated Assets	697,595					697,595	73
74								74
75	TOTALS	$ 863,927	$ 27,843	$ 27,843	$		$ 770,112	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	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	33,943	77
78										78
79										79
80	TOTALS			$ 65,824	$ 9,698	$ 9,698	$		$ 51,276	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)	$ 4,634,694	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 117,868	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 117,868	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)	$ 3,031,699	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: 07/01/11 Ending: 06/30/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: 07/01/11 Ending: 06/30/12

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.

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

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: 07/01/11 Ending: 06/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/12 (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	$ 1,520,757	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	193,510		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,523		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): GRANT RECEIVABLE	25,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,762,790	$	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	3,130,037		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	929,751		16
17	Accumulated Depreciation (book methods)	(3,031,699)		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)**	$ 1,602,995	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,365,785	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 72,033	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,227		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	122,911		36
37	NURSING HOME TAX	85,500		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 363,671	$	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)**	$ 363,671	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,002,114	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,365,785	$	48

***(See instructions.)**

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,929,500	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,929,500	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	72,614	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)**	$ 72,614	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)**	$ 3,002,114	24 *

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,723,943	1
2	Discounts and Allowances for all Levels	(65,067)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,658,876	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	25,000	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,597	13
14	Non-Patient Meals	18,410	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)**	$ 46,007	23
	D. Non-Operating Revenue		
24	Contributions	51,459	24
25	Interest and Other Investment Income***	1,960	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53,419	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS	2,178	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,178	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,760,480	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,048,386	31
32	Health Care	1,552,202	32
33	General Administration	793,141	33
	B. Capital Expense		
34	Ownership	117,868	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,940	36
	D. Other Expenses (specify):		
37	NURSING HOME TAX	143,329	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,687,866	40
41	**Income before Income Taxes (line 30 minus line 40)****	72,614	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 72,614	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 244,735	44
45	Private Pay - Net Inpatient Revenue	3,414,141	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,658,876	49

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

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

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

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	1,912	2,080	$ 58,344	$ 28.05	1
2	Assistant Director of Nursing	2,522	2,642	55,277	20.92	2
3	Registered Nurses	8,618	8,764	182,401	20.81	3
4	Licensed Practical Nurses	9,273	9,583	215,557	22.49	4
5	CNAs & Orderlies	49,917	51,547	599,185	11.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,057	2,173	22,544	10.37	8
9	Activity Director	1,964	2,106	36,961	17.55	9
10	Activity Assistants	9,342	9,945	94,547	9.51	10
11	Social Service Workers	1,824	2,048	41,313	20.17	11
12	Dietician					12
13	Food Service Supervisor	1,999	2,039	39,452	19.35	13
14	Head Cook	2,282	2,410	34,657	14.38	14
15	Cook Helpers/Assistants	21,924	23,115	205,868	8.91	15
16	Dishwashers					16
17	Maintenance Workers	5,405	5,623	82,173	14.61	17
18	Housekeepers	4,735	4,989	44,209	8.86	18
19	Laundry	3,903	4,168	35,219	8.45	19
20	Administrator	1,912	2,080	84,820	40.78	20
21	Assistant Administrator					21
22	Other Administrative	3,610	4,038	88,611	21.94	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	2,031	2,215	23,739	10.72	31
32	Other Health C: Nurses Aides	165,253	16,891	123,925	7.34	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	300,483	158,456	$ 2,068,802 *	$ 13.06	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	142	$ 5,664	Ln 1, Col 3	35
36	Medical Director	per visit	110	Ln 9, Col 3	36
37	Medical Records Consultant	15	900	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per record	3,098	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	5,280	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	157	$ 15,052		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	52	$ 2,214	Ln 10, Col 3	50
51	Licensed Practical Nurses	621	24,584	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	316	6,740	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	989	$ 33,538		53

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID SCARPETTA	EXEC DIR	NONE	$ 84,820
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 84,820

B. Administrative - Other

Description	Amount
NONE	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
SIKICH GARDNER & CO LLP	AUDIT / CONSULT	18,622
JMS ENTERPRISES	ACCOUNTING	10,700
DREYER FOOTE ETAL	LEGAL	18,796
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 48,118

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,869
Unemployment Compensation Insurance	49,135
FICA Taxes	160,341
Employee Health Insurance	155,643
Employee Meals	29,120
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE INCENTIVES	6,950
OTHER	1,508
TOTAL (agree to Schedule V, line 22, col.8)	$ 450,566

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	$ 3,980
Advertising: Employee Recruitment	7,834
Health Care Worker Background Check	360
(Indicate # of checks performed 36)	
Patient Background Checks 44	440
DUES & SUBSCRIPTIONS	3,608
ADVERTISING	25,965
Less: Public Relations Expense	( )
Non-allowable advertising	(9,323)
Yellow page advertising	(16,642)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,222

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,655
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,655

**See instructions.

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/11 Ending: 06/30/12

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. $ 32,940
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. $ 29,120 Has any meal income been offset against related costs? YES Indicate the amount. $ 18,410

(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 6/30/12**
ID: 0010371
SUPPLEMENTAL INFORMATION

OTHER REVENUE DETAIL - PAGE 19, LINE 28

OTHER MISC INCOME	2,178
TOTAL	2,178

OTHER EXPENSES - PAGE 4, LINE 43

NURSING HOME TAX	143,329
TOTAL	143,329

RECLASSES - PAGE 3

COST OF EMPLOYEE MEALS RECLASSED:

FROM COL 2, LINE ------>	2	(29,120)
TO COL 3, LINE ------>	22	29,120

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
1 STAFF	12/8/2011	IL	END STAGE DISEASES	PESI	179.00
2 NURSES	2/24/2012	IL	GERIATRIC ASSESS TO(	SUMMIT	338.00
1 NURSE	10/20/2011	IL	WHEEL CHAIR SEATING	SUMMIT	179.00
2 NURSES	1/27/2012	IL	ELDERLAW	HEALTH ED	338.00
1 STAFF	5/17/2012	IL	THERAPEUTIC YOGA	CROSS COUNTRY ED	189.00
VARIOUS NURSING STA	VARIOUS	ONLINE	VARIOUS	UPSTAIRS SOLUTIONS	432.00

LISTING OF BOARD OF DIRECTORS

Office	Name	Service Provided	Ownership of other entities
President	Lynn Akers	none	none
Vice President	Jack Smith	none	none
Secretary	Atty. James Cheatham	none	none
Treasurer	Douglas Cheatham	none	none
Trustee	Michael Marzec, MD	none	none
Trustee	Mollie Millen	none	none
Trustee	Senator Robert Mitchler	none	none
Trustee	Judge Tim McCann	none	none
Trustee	Mark Baum	none	none
Trustee	Joseph Jacobs	none	none

Legal Bills to be attached to the 6/30/12 Cost Report

Date	Reference	Name	Amt
7/31/11	15904-004Ml	Law Firm of Dreyer, Foote, Str	730.66
7/31/11	15904-008Mm	Law Firm of Dreyer, Foote, Str	211.10
8/31/11	15904-000Mm	Law Firm of Dreyer, Foote, Str	670.00
11/1/11	15904-000Mo	Law Firm of Dreyer, Foote, Str	916.10
11/1/11	15904-004Mo	Law Firm of Dreyer, Foote, Str	461.10
11/1/11	15904-008Mp	Law Firm of Dreyer, Foote, Str	1,572.56
12/31/11	15904-000Mp	Law Firm of Dreyer, Foote, Str	120.00
2/1/12	15904-004Mq	Law Firm of Dreyer, Foote, Str	520.00
2/1/12	15904-000Mq	Law Firm of Dreyer, Foote, Str	120.00
2/1/12	15904-007Mq	Law Firm of Dreyer, Foote, Str	50.00
2/1/12	15904-008Mr	Law Firm of Dreyer, Foote, Str	350.00
12/1/11	15904-000Mk	Law Firm of Dreyer, Foote, Str	300.00
12/31/11	15904-004Mp	Law Firm of Dreyer, Foote, Str	1,547.10
9/30/11	15904-007Mo	Law Firm of Dreyer, Foote, Str	224.15
12/31/11	15904-007Mp	Law Firm of Dreyer, Foote, Str	611.10
2/29/12	15904-007Ms	Law Firm of Dreyer, Foote, Str	250.00
4/1/12	15904-007Mt	Law Firm of Dreyer, Foote, Str	912.20
4/30/12	15904-007Mu	Law Firm of Dreyer, Foote, Str	1,078.10
7/31/11	15094-012Ma	Law Firm of Dreyer, Foote, Str	1,286.00
8/31/11	15904-004Mm	Law Firm of Dreyer, Foote, Str	352.00
12/1/11	15904004Mk	Law Firm of Dreyer, Foote, Str	441.10
2/29/12	15904-004Ms	Law Firm of Dreyer, Foote, Str	311.10
8/31/11	15904-008Mn	Law Firm of Dreyer, Foote, Str	371.10
9/30/11	15904-008Mo	Law Firm of Dreyer, Foote, Str	1,161.10
12/31/11	15904-008Mq	Law Firm of Dreyer, Foote, Str	721.10
2/29/12	15904-008Ms	Law Firm of Dreyer, Foote, Str	305.60
4/1/12	15904-008Mt	Law Firm of Dreyer, Foote, Str	97.96
4/30/12	15904-008Mu	Law Firm of Dreyer, Foote, Str	663.14
5/31/12	15904-0008Mv	Law Firm of Dreyer, Foote, Str	1,324.24
8/31/11	15904-012Mm	Law Firm of Dreyer, Foote, Str	17.24
9/30/11	15904-012Mo	Law Firm of Dreyer, Foote, Str	1,100.00

18,795.85