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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CATHY FLANAGAN **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 7/1/2014 to 6/30/2015 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) CATHY FLANAGAN
(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 # ( )

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: 7/1/2014 Ending: 6/30/2015

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	2,412			2,412	8
9	SNF/PED					9
10	ICF		14,921		14,921	10
11	ICF/DD					11
12	SC		31,349		31,349	12
13	DD 16 OR LESS					13
14	TOTALS	2,412	46,270		48,682	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.83%

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 [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: 7/1/2014 Ending: 6/30/2015

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	292,484	3,437	4,752	300,673		300,673		300,673			1
2	Food Purchase		350,755		350,755	(35,594)	315,161	(14,284)	300,877			2
3	Housekeeping	50,074	30,929	25,810	106,813		106,813		106,813			3
4	Laundry	24,874	8,535	3,040	36,449		36,449		36,449			4
5	Heat and Other Utilities			132,009	132,009		132,009		132,009			5
6	Maintenance	71,959	11,119	64,409	147,487		147,487		147,487			6
7	Other (specify):*											7
8	TOTAL General Services	439,391	404,775	230,020	1,074,186	(35,594)	1,038,592	(14,284)	1,024,308			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,295,820	55,060	35,818	1,386,698		1,386,698		1,386,698			10
10a	Therapy											10a
11	Activities	131,868	1,633		133,501		133,501		133,501			11
12	Social Services	43,816		7,013	50,829		50,829		50,829			12
13	CNA Training											13
14	Program Transportation			5,370	5,370		5,370	(1,873)	3,497			14
15	Other (specify):*			101,170	101,170		101,170		101,170			15
16	TOTAL Health Care and Programs	1,471,504	56,693	149,371	1,677,568		1,677,568	(1,873)	1,675,695			16
	C. General Administration											
17	Administrative	81,160			81,160		81,160		81,160			17
18	Directors Fees											18
19	Professional Services			32,410	32,410		32,410		32,410			19
20	Dues, Fees, Subscriptions & Promotions			16,584	16,584		16,584	(13,032)	3,552			20
21	Clerical & General Office Expenses	96,958	2,863	41,241	141,062		141,062		141,062			21
22	Employee Benefits & Payroll Taxes			418,558	418,558	35,594	454,152		454,152			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,927	1,927		1,927		1,927			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			78,381	78,381		78,381		78,381			26
27	Other (specify):*											27
28	TOTAL General Administration	178,118	2,863	589,101	770,082	35,594	805,676	(13,032)	792,644			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,089,013	464,331	968,492	3,521,836		3,521,836	(29,189)	3,492,647			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:** 7/1/2014 **Ending:** 6/30/2015

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			111,212	111,212		111,212		111,212			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**			111,212	111,212		111,212		111,212			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)**	2,089,013	464,331	1,112,554	3,665,898		3,665,898	(29,189)	3,636,709			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: 7/1/2014 Ending: 6/30/2015

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	(14,284)	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)	(1,873)	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	(2,770)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(10,262)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (29,189)		$	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))**	$ (29,189)		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: 7/1/2014

Ending: 6/30/2015

	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:** 7/1/2014 **Ending:** 6/30/2015

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,284)	0	0	0	0	0	0	0	0	0	0	(14,284)	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**	(14,284)	0	0	0	0	0	0	0	0	0	0	(14,284)	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	(1,873)	0	0	0	0	0	0	0	0	0	0	(1,873)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,873)	0	0	0	0	0	0	0	0	0	0	(1,873)	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	(13,032)	0	0	0	0	0	0	0	0	0	0	(13,032)	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**	(13,032)	0	0	0	0	0	0	0	0	0	0	(13,032)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(29,189)	0	0	0	0	0	0	0	0	0	0	(29,189)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JENNINGS TERRACE # 0010371 **Report Period Beginning:** 7/1/2014 **Ending:** 6/30/2015

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)**	(29,189)	0	0	0	0	0	0	0	0	0	0	(29,189)	45

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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
SEE SUPP PAGE FOR BOARD OF DIRECTORS LISTING						

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 [X] 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: 7/1/2014 Ending: 6/30/2015

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	LYNN AKERS	BOD						1
2	DUANNE KLECKNER	BOD						2
3	ATTY JAMES CHEATHAM	BOD						3
4	DOUGLAS CHEATHAM	BOD						4
5	MICHAEL MARZEC MD	BOD						5
6	MOLLIE MILLEN	BOD						6
7	TIM McCANN	BOD						7
8	JOSEPH JACOBS	BOD						8
9	JESS TOUSSAINT	BOD						9
10	JONATHAN BIERITZ	BOD						10
11	MARIAN MOORE	BOD						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: 7/1/2014 Ending: 6/30/2015

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 7/1/2014 Ending: 6/30/2015

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: 7/1/2014 Ending: 6/30/2015

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: 7/1/2014 Ending: 6/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		12

THIS SCHEDULE IS N/A

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 7/1/2014 Ending: 6/30/2015

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: 7/1/2014 Ending: 6/30/2015

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		1,381,821	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		2,755	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		4,219	18
19	BUILDING IMPROVEMENT - RETAINING WALL			2000	8,361	334	40	334		4,170	19
20	BUILDING IMPROVEMENT - HANDICAPPED ENTRY			2000	43,900	1,756	40	1,756		22,097	20
21	BUILDING IMPROVEMENT - RETAINING WALL			2001	8,361	334	40	334		4,135	21
22	BUILDING IMPROVEMENT - WINDOWS			2001	2,666		10			2,666	22
23	BUILDING IMPROVEMENT - KITCHEN FLOOR / WINDOWS			2002	14,456	994	VAR	994		13,958	23
24	BUILDING IMPROVEMENT - KITCHEN RENOVATION / DOOR			2003	7,541		VAR			7,541	24
25	BUILDING IMPROVEMENT - MAIN BREAKER			2005	8,900	890	10	890		8,754	25
26	BUILDING IMPROVEMENT - DOOR / HVAC IMPROVEMENTS			2005	4,150		10			4,150	26
27	BUILDING IMPROVEMENT - WATER PIPE / CARPETING			2006	7,157	399	VAR	399		7,157	27
28	BUILDING IMPROVEMENT - ROOF, WIRING, FLOORING			2007	24,900	2,490	10	2,490		22,410	28
29	BUILDING IMPROVEMENT - LOCKER ROOM REMODEL			2008	7,500	750	10	750		5,625	29
30	BUILDING IMPROVEMENT - BATHROOM REMODEL			2008	44,531	2,969	15	2,969		22,267	30
31	BUILDING IMPROVEMENT - ROOF REPAIR			2008	7,909	791	10	791		5,933	31
32	BUILDING IMPROVEMENT - ROOF REPAIR			2009	15,332	1,533	10	1,533		10,731	32
33	BUILDING IMPROVEMENT - CARPETING			2010	9,033	901	5	901		9,033	33
34	BUILDING IMPROVEMENT - ROOF REPAIR			2011	12,943	1,294	10	1,294		5,823	34
35	BUILDING IMPROVEMENT - REMODEL SHOWERS			2011	26,801	1,787	15	1,787		8,042	35
36	BUILDING IMPROVEMENT - WALL HEATER, RAILINGS			2011	9,095	1,102	VAR	1,102		4,959	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: 7/1/2014 Ending: 6/30/2015

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	$ 790	10	$ 790	$	$ 2,765	37
38	BUILDING IMPROVEMENT - CARPETING	2012	5,525	1,105	5	1,105		3,868	38
39	BUILDING IMPROVEMENT - NEW ROOF	2012	80,440	5,363	15	5,363		18,769	39
40	BUILDING IMPROVEMENT - EMERGENCY CIRCUITS	2012	4,985	712	7	712		2,848	40
41	BUILDING IMPROVEMENT - MULTIPURPOSE RM WINDOWS	2013	4,000	400	10	400		1,000	41
42	BUILDING IMPROVEMENT - NEW FLOORING ANNEX	2014	41,170	4,117	10	4,117		6,175	42
43	BUILDING IMPROVEMENT - NEW FLOORING ANNEX	2015	55,173	2,758	10	2,758		2,758	43
44	LAND IMP - PARKING LOT	1974	470		7			470	44
45	LAND IMP - PARKING LOT	1985	880		7			880	45
46	LAND IMP - PARKING LOT	1992	7,445		10			7,445	46
47	LAND IMP - PARKING LOT - BLACKTOP	2001	7,549		10			7,549	47
48	LAND IMP - PARKING LOT - FRONT ENTRANCE	2003	30,959		10			30,959	48
49	LAND IMP - PARKING LOT - LIGHTS	2010	3,518	352	10	352		1,936	49
50	LAND IMP - PARKING LOT - RESURFACE	2013	6,389	640	10	640		1,597	50
51									51
52	LAND IMP - VARIOUS	1978	2,317		10			2,317	52
53	LAND IMP - VARIOUS	1982	1,007		10			1,007	53
54	LAND IMP - VARIOUS	1988	4,084		10			4,084	54
55	LAND IMP - YARD LIGHTS	1989	1,390		15			1,390	55
56	LAND IMP - SIDEWALK	1990	1,450		10			1,450	56
57	LAND IMP - SIDEWALK	1991	600		10			600	57
58	LAND IMP - SIDEWALK	1994	440		15			440	58
59	LAND IMP - SIDEWALK	1998	1,592		10			1,592	59
60	LAND IMP - SIDEWALK	2002	225		10			225	60
61	LAND IMP - FENCE	2003	3,581		10			3,581	61
62	LAND IMP - FENCE	2004	4,353	220	10	220		4,353	62
63	LAND IMP - TREE REMOVAL / CONCRETE	2005	15,812	1,581	10	1,581		14,801	63
64	LAND IMP - TERRACE	2010	35,935	2,396	15	2,396		13,178	64
65	LAND IMP - CONCRETE WORK	2011	3,332	333	10	333		1,665	65
66	LAND IMP - EASTSIDE ENTRY	2014	6,400	640	10	640		1,280	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,243,169	$ 86,740		$ 86,740	$	$ 2,464,380	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: 7/1/2014 Ending: 6/30/2015

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	$ 154,391	$ 23,677	$ 23,677	$		$ 102,336	71
72	Current Year Purchases	7,951	795	795		5	795	72
73	Fully Depreciated Assets	751,814					751,814	73
74								74
75	TOTALS	$ 914,156	$ 24,472	$ 24,472	$		$ 854,945	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				$	$	$	$		$	76
77	RESIDENT / STAFF TRANS	08 STARCRAFT VAN	2009	48,491				5	48,491	77
78										78
79										79
80	TOTALS			$ 48,491	$	$	$		$ 48,491	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)	$ 4,780,722	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 111,212	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 111,212	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)	$ 3,367,816	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: 7/1/2014 Ending: 6/30/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: 7/1/2014 Ending: 6/30/2015

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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: 7/1/2014 Ending: 6/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/2015 (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	$ 2,074,087	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	77,686		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,973		6
7	Other Prepaid Expenses	5,368		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,185,114	$	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	3,243,169		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	962,647		16
17	Accumulated Depreciation (book methods)	(3,367,816)		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)**	$ 1,412,906	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,598,020	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,542	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	103,190		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	123,703		36
37	NURSING HOME TAX	42,500		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 348,935	$	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)**	$ 348,935	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,229,085	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,578,020	$	48

***(See instructions.)**

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,890,939	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,890,939	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	338,146	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)**	$ 338,146	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)**	$ 3,229,085	24 *

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

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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	$ 3,975,346	1
2	Discounts and Allowances for all Levels	(22,500)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,952,846	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	2,208	13
14	Non-Patient Meals	14,284	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)**	$ 16,492	23
	D. Non-Operating Revenue		
24	Contributions	26,412	24
25	Interest and Other Investment Income***	1,660	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,072	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION INCOME	1,873	28
28a	OTHER INCOME	4,761	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,634	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,004,044	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,074,186	31
32	Health Care	1,677,568	32
33	General Administration	770,082	33
	B. Capital Expense		
34	Ownership	111,212	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)***	$ 3,665,898	40
41	**Income before Income Taxes (line 30 minus line 40)****	338,146	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 338,146	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 258,087	44
45	Private Pay - Net Inpatient Revenue	3,694,759	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)	$ 3,952,846	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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: 7/1/2014 Ending: 6/30/2015

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	$ 58,521	$ 28.14	1
2	Assistant Director of Nursing	2,500	2,324	53,785	23.14	2
3	Registered Nurses	6,555	6,749	147,910	21.92	3
4	Licensed Practical Nurses	11,410	11,781	251,056	21.31	4
5	CNAs & Orderlies	36,368	39,184	541,133	13.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,925	2,053	22,467	10.94	8
9	Activity Director	2,074	2,244	42,485	18.93	9
10	Activity Assistants	8,308	8,871	89,383	10.08	10
11	Social Service Workers	1,753	1,973	43,816	22.21	11
12	Dietician					12
13	Food Service Supervisor	1,790	2,042	42,998	21.06	13
14	Head Cook	4,353	4,601	67,765	14.73	14
15	Cook Helpers/Assistants	20,071	21,053	181,721	8.63	15
16	Dishwashers					16
17	Maintenance Workers	4,141	4,382	71,959	16.42	17
18	Housekeepers	5,029	5,586	50,074	8.96	18
19	Laundry	2,703	2,875	24,874	8.65	19
20	Administrator	1,665	1,961	81,160	41.39	20
21	Assistant Administrator					21
22	Other Administrative	3,669	3,895	96,958	24.89	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	1,873	2,073	23,328	11.25	31
32	Other Health C: NURSE AIDES	22,979	23,493	197,620	8.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,078	149,220	$ 2,089,013 *	$ 14.00	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	113	$ 4,752	Ln 1, Col 3	35
36	Medical Director				36
37	Medical Records Consultant	13	750	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	per visit	7,013	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	126	$ 12,515		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	17	$ 977	Ln 10, Col 3	50
51	Licensed Practical Nurses	61	2,443	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	1,047	23,743	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	1,125	$ 27,163		53

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DAVID SCARPETTA	EXEC DIR	NONE	$ 58,597
HARRY POOLE	INTERIM ADMIN	NONE	22,563
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,160

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 LLP	AUDIT / CONSULT	$ 10,900
JMS ENTERPRISES	ACCOUNTING	10,675
DREYER FOOTE ETAL	LEGAL	6,146
JB ARCHITECTURE	CONSULT	4,689
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 32,410

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 42,439
Unemployment Compensation Insurance	52,408
FICA Taxes	156,864
Employee Health Insurance	156,537
Employee Meals	35,594
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE INCENTIVES	7,400
OTHER	2,910
TOTAL (agree to Schedule V, line 22, col.8)	$ 454,152

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	$
Advertising: Employee Recruitment	2,002
Health Care Worker Background Check	
(Indicate # of checks performed 60)	725
Patient Background Checks 69	825
ADVERTISING	13,032
Less: Public Relations Expense	( )
Non-allowable advertising	(2,770)
Yellow page advertising	(10,262)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,552

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,927
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,927

**See instructions.

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 7/1/2014 Ending: 6/30/2015

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: 7/1/2014 Ending: 6/30/2015

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? **N/A**

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

(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. $ **35,594** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **14,284**

(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: **SLUPIK AND ASSOCIATES**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

JENNINGS TERRACE, INC **COST REPORT FOR 6/30/15**
ID: 0010371
SUPPLEMENTAL INFORMATION

OTHER REVENUE DETAIL - PAGE 19, LINE 28a

MISCELLANEOUS INCOME	4,761
TOTAL	4,761

OTHER EXPENSES - PAGE 3, LINE 15

NURSING HOME TAX	101,170
TOTAL	101,170

RECLASSES - PAGE 3

COST OF EMPLOYEE MEALS RECLASSED:

FROM COL 2, LINE ------>	2	(35,594)
TO COL 3, LINE ------>	22	35,594

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
EXEC DIR	11/06/2014	SCHAUMBURG	Fall Prevention	HIN	429.00
VAR DIETARY	10/24/2014	ON SITE	Sanitation Classes	David Williams	900.00
EXEC DIR	10/29/2014	NAPERVILLE	Readmission Prevention	College of Medicine	129.00
NURSING STAFF	12/10/2014	NAPERVILLE	Depression & BiPolar	INR	162.00
FOOD SERV SUP	02/17/2015	ROSEMONT	Nutrition	ANFP	149.00
NURSING STAFF	05/22/2015	JOLIET	Reasoning with Unreason	IBP	158.00

1,927.00

JENNINGS TERRACE INC **COST REPORT FOR 6/30/15**

ID: 0010371

LISTING OF LEGAL FEES - INVOICES ATTACHED

07/01/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	431.10
07/31/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	330.00
08/31/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	120.00
10/01/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	742.85
11/01/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	100.00
11/30/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	961.10
11/30/2014	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	220.00
12/31/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	440.00
02/17/2015	15904-004M	Law Firm of Dreyer, Foote, Streit, Furg	112.50
02/17/2015	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	430.00
02/17/2015	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	1,417.20
03/01/2015	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	20.00
03/01/2015	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	245.00
03/31/2015	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	411.10
05/01/2015	15904-004M	Law Firm of Dreyer, Foote, Streit, Furg	165.00
			6,145.85