		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.

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[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: 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 07/01/2015 to 06/30/2016 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) THEODORE F SLUPIK, CPA
(Firm Name & Address) SLUPIK AND ASSOCIATES, LTD. 1700 PARK STREET SUITE 201, NAPERVILLE, IL 60563
(Telephone) (630) 357-0096 Fax # (630) 357-0592

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: 07/01/2015 Ending: 06/30/2016

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	2,691			2,691	8
9	SNF/PED					9
10	ICF		15,539		15,539	10
11	ICF/DD					11
12	SC		34,473		34,473	12
13	DD 16 OR LESS					13
14	TOTALS	2,691	50,012		52,703	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.58%

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 03/16/1943

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

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

Medicare Intermediary ______

IV. ACCOUNTING BASIS

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

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

Tax Year: JUNE 30 Fiscal Year: JUNE 30

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

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	312,693	4,210	8,601	325,504		325,504		325,504			1
2	Food Purchase		362,620		362,620	(36,978)	325,642	(11,936)	313,706			2
3	Housekeeping	63,853	49,848	28,131	141,832		141,832		141,832			3
4	Laundry	29,773	2,341	592	32,706		32,706		32,706			4
5	Heat and Other Utilities			123,089	123,089		123,089		123,089			5
6	Maintenance	102,352	5,792	79,548	187,692		187,692		187,692			6
7	Other (specify):*											7
8	TOTAL General Services	508,671	424,811	239,961	1,173,443	(36,978)	1,136,465	(11,936)	1,124,529			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,305,052	67,342	45,316	1,417,710		1,417,710		1,417,710			10
10a	Therapy											10a
11	Activities	136,790	735		137,525		137,525		137,525			11
12	Social Services	42,384		3,833	46,217		46,217		46,217			12
13	CNA Training											13
14	Program Transportation			7,925	7,925		7,925	(1,274)	6,651			14
15	Other (specify):*			114,332	114,332		114,332		114,332			15
16	TOTAL Health Care and Programs	1,484,226	68,077	171,406	1,723,709		1,723,709	(1,274)	1,722,435			16
	C. General Administration											
17	Administrative	91,955			91,955		91,955		91,955			17
18	Directors Fees											18
19	Professional Services			24,715	24,715		24,715		24,715			19
20	Dues, Fees, Subscriptions & Promotions			19,810	19,810		19,810	(12,844)	6,966			20
21	Clerical & General Office Expenses	113,035	16,689	47,461	177,185		177,185		177,185			21
22	Employee Benefits & Payroll Taxes			390,042	390,042	36,978	427,020		427,020			22
23	Inservice Training & Education											23
24	Travel and Seminar			190	190		190		190			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			78,705	78,705		78,705		78,705			26
27	Other (specify):*											27
28	TOTAL General Administration	204,990	16,689	560,923	782,602	36,978	819,580	(12,844)	806,736			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,197,887	509,577	972,290	3,679,754		3,679,754	(26,054)	3,653,700			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: 07/01/2015 Ending: 06/30/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			110,948	110,948		110,948		110,948			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			110,948	110,948		110,948		110,948			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):*											43
44	TOTAL Special Cost Centers			32,940	32,940		32,940		32,940			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,197,887	509,577	1,116,178	3,823,642		3,823,642	(26,054)	3,797,588			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:** 07/01/2015 **Ending:** 06/30/2016

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	(11,936)	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)	(1,274)	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	(3,112)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(9,732)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,054)		$	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))**	$ (26,054)		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: 07/01/2015

Ending: 06/30/2016

	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: 07/01/2015 Ending: 06/30/2016

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	(11,936)	0	0	0	0	0	0	0	0	0	0	(11,936)	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**	(11,936)	0	0	0	0	0	0	0	0	0	0	(11,936)	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	(1,274)	0	0	0	0	0	0	0	0	0	0	(1,274)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,274)	0	0	0	0	0	0	0	0	0	0	(1,274)	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	(12,844)	0	0	0	0	0	0	0	0	0	0	(12,844)	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**	(12,844)	0	0	0	0	0	0	0	0	0	0	(12,844)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,054)	0	0	0	0	0	0	0	0	0	0	(26,054)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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)**	(26,054)	0	0	0	0	0	0	0	0	0	0	(26,054)	45

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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 ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	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: 07/01/2015 Ending: 06/30/2016

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	JOSEPH JACOBS	BOD						1
2	MOLLIE MILLEN	BOD						2
3	JONATHAN BIERITZ	BOD						3
4	JAMES CHEATHAM	BOD						4
5	DOUGLAS CHEATHAM	BOD						5
6	LYNN AKERS	BOD						6
7	MICHAEL MARZEC	BOD						7
8	TIM MCCANN	BOD						8
9	JACK SMITH	BOD						9
10	JESS TOUISSANT	BOD						10
11	MARK BAUM	BOD						11
12	DUANNE KLECKNER	BOD						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: 07/01/2015 Ending: 06/30/2016

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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 07/01/2015 Ending: 6/30/2016

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 [X]

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: 07/01/2015 Ending: 06/30/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	THIS SCHEDULE IS N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

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

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

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

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item	Amount	Line
1. Real Estate Tax accrual used on 2015 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 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

FOR BHF USE ONLY

Line	Description	Amount	Line
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.**

2015 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 2015 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 2015.

	(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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 07/01/2015 Ending: 06/30/2016

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? [X] (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? [X] (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 [X] 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: 07/01/2015 Ending: 06/30/2016

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		1,428,400	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		2,865	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		4,541	18
19	BUILDING IMPROVEMENT - RETAINING WALL			2000	8,361	334	40	334		4,505	19
20	BUILDING IMPROVEMENT - HANDICAPPED ENTRY			2000	43,900	1,756	40	1,756		23,853	20
21	BUILDING IMPROVEMENT - RETAINING WALL			2001	8,361	334	40	334		4,470	21
22	BUILDING IMPROVEMENT - WINDOWS			2001	2,666		10			2,666	22
23	BUILDING IMPROVEMENT - KITCHEN FLOOR / WINDOWS			2002	14,456	497	VAR	497		14,456	23
24	BUILDING IMPROVEMENT - KITCHEN RENOVATION / DOOR			2003	7,541		VAR			7,541	24
25	BUILDING IMPROVEMENT - MAIN BREAKER			2005	8,900	146	10	146		8,900	25
26	BUILDING IMPROVEMENT - DOOR / HVAC IMPROVEMENTS			2005	4,150		10			4,150	26
27	BUILDING IMPROVEMENT - WATER PIPE / CARPETING			2006	7,157		VAR			7,157	27
28	BUILDING IMPROVEMENT - ROOF, WIRING, FLOORING			2007	24,900	2,488	10	2,488		24,900	28
29	BUILDING IMPROVEMENT - LOCKER ROOM REMODEL			2008	7,500	750	10	750		6,375	29
30	BUILDING IMPROVEMENT - BATHROOM REMODEL			2008	44,531	2,969	15	2,969		25,236	30
31	BUILDING IMPROVEMENT - ROOF REPAIR			2008	7,909	791	10	791		6,724	31
32	BUILDING IMPROVEMENT - ROOF REPAIR			2009	15,332	1,533	10	1,533		12,264	32
33	BUILDING IMPROVEMENT - CARPETING			2010	9,033		5			9,033	33
34	BUILDING IMPROVEMENT - ROOF REPAIR			2011	12,943	1,294	10	1,294		7,118	34
35	BUILDING IMPROVEMENT - REMODEL SHOWERS			2011	26,801	1,787	15	1,787		9,829	35
36	BUILDING IMPROVEMENT - WALL HEATER, RAILINGS			2011	9,095	1,102	VAR	1,102		6,061	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: 07/01/2015 Ending: 06/30/2016

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	$	$ 3,555	37
38	BUILDING IMPROVEMENT - CARPETING	2012	5,525	1,105	5	1,105		4,973	38
39	BUILDING IMPROVEMENT - NEW ROOF	2012	80,440	5,363	15	5,363		24,133	39
40	BUILDING IMPROVEMENT - EMERGENCY CIRCUITS	2012	4,985	712	7	712		3,560	40
41	BUILDING IMPROVEMENT - MULTIPURPOSE RM WINDOW	2013	4,000	400	10	400		1,400	41
42	BUILDING IMPROVEMENT - NEW FLOORING ANNEX	2014	41,170	4,117	10	4,117		10,292	42
43	BUILDING IMPROVEMENT - NEW FLOORING ANNEX	2015	55,173	5,517	10	5,517		8,276	43
44	BUILDING IMPROVEMENT - GENERATOR	2016	38,037	1,902	10	1,902		1,902	44
45	BUILDING IMPROVEMENT - COOLING TOWER	2016	28,175	939	15	939		939	45
46	BUILDING IMPROVEMENT - NURSES STATION	2016	2,895	290	5	290		290	46
47	LAND IMP - PARKING LOT	1974	470		7			470	47
48	LAND IMP - PARKING LOT	1985	880		7			880	48
49	LAND IMP - PARKING LOT	1992	7,445		10			7,445	49
50	LAND IMP - PARKING LOT - BLACKTOP	2001	7,549		10			7,549	50
51	LAND IMP - PARKING LOT - FRONT ENTRANCE	2003	30,959		10			30,959	51
52	LAND IMP - PARKING LOT - LIGHTS	2010	3,518	352	10	352		2,288	52
53	LAND IMP - PARKING LOT - RESURFACE	2013	6,389	639	10	639		2,236	53
54	LAND IMP - VARIOUS	1978	2,317		10			2,317	54
55	LAND IMP - VARIOUS	1982	1,007		10			1,007	55
56	LAND IMP - VARIOUS	1988	4,084		10			4,084	56
57	LAND IMP - YARD LIGHTS	1989	1,390		15			1,390	57
58	LAND IMP - SIDEWALK	1990	1,450		10			1,450	58
59	LAND IMP - SIDEWALK	1991	600		10			600	59
60	LAND IMP - SIDEWALK	1994	440		15			440	60
61	LAND IMP - SIDEWALK	1998	1,592		10			1,592	61
62	LAND IMP - SIDEWALK	2002	225		10			225	62
63	LAND IMP - FENCE	2003	3,581		10			3,581	63
64	LAND IMP - FENCE	2004	4,353		10			4,353	64
65	LAND IMP - TREE REMOVAL / CONCRETE	2005	15,812	1,011	10	1,011		15,812	65
66	LAND IMP - TERRACE	2010	35,935	2,396	15	2,396		15,572	66
67	LAND IMP - CONCRETE WORK	2011	3,332	333	10	333		1,998	67
68	LAND IMP - EASTSIDE ENTRY	2014	6,400	640	10	640		1,920	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,312,276	$ 89,296		$ 89,296	$	$ 2,553,684	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: 07/01/2015 Ending: 06/30/2016

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	$ 130,870	$ 18,974	$ 18,974	$		$ 90,626	71
72	Current Year Purchases	43,469	2,678	2,678		7	2,678	72
73	Fully Depreciated Assets	783,285					783,285	73
74								74
75	TOTALS	$ 957,624	$ 21,652	$ 21,652	$		$ 876,589	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 TRANSI	08 STARCRAFT VAN	2009	$ 48,491	$	$	$	5	$ 48,491	76
77										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)	$ 4,893,297	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 110,948	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 110,948	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)	$ 3,478,764	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: 07/01/2015 Ending: 06/30/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 07/01/2015 Ending: 06/30/2016

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
   - [X] 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.

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2016 (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	$ 2,481,152	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 133,799)	172,259		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,109		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,696,520	$	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	3,312,275		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,006,117		16
17	Accumulated Depreciation (book methods)	(3,478,764)		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)**	$ 1,414,534	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,111,054	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,488	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,973		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	157,237		36
37	NURSING HOME TAX	46,199		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 321,897	$	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)**	$ 321,897	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,789,157	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,111,054	$	48

*(See instructions.)

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,229,085	1
2	Restatements (describe):		2
3	CONTRIBUTIONS NOT REPORTED 6/30/2015	20,000	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,249,085	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	540,072	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)**	$ 540,072	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)**	$ 3,789,157	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

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	$ 4,261,299	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,261,299	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	2,788	13
14	Non-Patient Meals	11,936	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)**	$ 14,724	23
	D. Non-Operating Revenue		
24	Contributions	77,852	24
25	Interest and Other Investment Income***	3,930	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 81,782	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	TRANSPORTATION INCOME	1,274	28
28a	OTHER INCOME	4,635	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,909	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,363,714	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,173,443	31
32	Health Care	1,723,709	32
33	General Administration	782,602	33
	B. Capital Expense		
34	Ownership	110,948	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	32,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,823,642	40
41	**Income before Income Taxes (line 30 minus line 40)****	540,072	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 540,072	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 384,236	44
45	Private Pay - Net Inpatient Revenue	3,877,063	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)	$ 4,261,299	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES 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: 07/01/2015 Ending: 06/30/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,725	1,869	$ 53,636	$ 28.70	1
2	Assistant Director of Nursing	1,985	2,169	46,894	21.62	2
3	Registered Nurses	11,588	11,890	254,515	21.41	3
4	Licensed Practical Nurses	9,784	10,118	196,510	19.42	4
5	CNAs & Orderlies	56,085	58,353	651,661	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,001	6,396	62,781	9.82	8
9	Activity Director	2,065	2,209	40,176	18.19	9
10	Activity Assistants	8,816	9,141	96,614	10.57	10
11	Social Service Workers	1,648	1,942	42,384	21.82	11
12	Dietician					12
13	Food Service Supervisor	1,900	1,981	42,834	21.62	13
14	Head Cook	4,406	4,598	69,278	15.07	14
15	Cook Helpers/Assistants	22,615	23,113	200,581	8.68	15
16	Dishwashers					16
17	Maintenance Workers	6,209	6,425	102,352	15.93	17
18	Housekeepers	6,913	7,157	63,853	8.92	18
19	Laundry	3,119	3,199	29,773	9.31	19
20	Administrator	2,112	2,112	91,661	43.40	20
21	Assistant Administrator					21
22	Other Administrative	4,218	4,382	113,329	25.86	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	1,934	2,094	24,231	11.57	31
32	Other Health Care(specify)					32
33	Other(specify) NURSE AIDES	1,968	1,968	14,824	7.53	33
34	TOTAL (lines 1 - 33)	155,091	161,116	$ 2,197,887 *	$ 13.64	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	172	$ 8,601	Ln 1, Col 3	35
36	Medical Director				36
37	Medical Records Consultant	13	780	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	33	2,890	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	218	$ 12,271		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 713	Ln 10, Col 3	50
51	Licensed Practical Nurses	183	7,308	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	916	21,385	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	1,115	$ 29,406		53

STATE OF ILLINOIS

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2015 Ending: 06/30/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
CATHY FLANAGAN	EXEC DIR	NONE	$	79,529
HARRY POOLE	INTERIM DIR	NONE		12,426
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	91,955

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	$	630
SLUPIK AND ASSOCIATES	AUDIT / CONSULT		9,075
JMS ENTERPRISES	ACCOUNTING		9,000
WEBER & ASSOCIATES	ACCOUNTING		4,000
DREYER FOOTE ETAL	LEGAL		2,010
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	24,715

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	43,406
Unemployment Compensation Insurance		39,310
FICA Taxes		164,939
Employee Health Insurance		131,631
Employee Meals		36,978
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE INCENTIVES		8,390
OTHER		2,366
TOTAL (agree to Schedule V, line 22, col.8)	$	427,020

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		314
Health Care Worker Background Check		
(Indicate # of checks performed 18)		340
Patient Background Checks 51		410
ADVERTISING		12,844
DUES & SUBSCRIPTIONS		1,922
Less: Public Relations Expense		( )
Non-allowable advertising		(3,112)
Yellow page advertising		(9,732)
TOTAL (agree to Sch. V, line 20, col. 8)	$	6,966

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		190
Entertainment Expense		( )
TOTAL (agree to Sch. V, line 24, col. 8)	$	190

**See instructions.

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. **N/A**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 YRS**

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

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

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(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. $ **36,978** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **11,936**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **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. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **SLUPIK AND ASSOCIATES, LTD.**

(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 6/30/2016
ID: 0010371
LISTING OF LEGAL FEES

Date	Reference	Vendor		Amount
07/01/2015	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	$	100.00
09/30/2015	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg		190.00
10/31/2015	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg		160.00
02/01/2016	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg		100.00
03/01/2016	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg		90.00
03/31/2016	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg		520.00
03/31/2016	15904-017M	Law Firm of Dreyer, Foote, Streit, Furg		190.00
04/30/2016	15904-008M	Law Firm of Dreyer, Foote, Streit, Furg		100.00
04/30/2016	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg		50.00
05/31/2016	15904-008M	Law Firm of Dreyer, Foote, Streit, Furg		60.00
06/30/2016	15904-000m	Law Firm of Dreyer, Foote, Streit, Furg		200.00
06/30/2016	15904-008m	Law Firm of Dreyer, Foote, Streit, Furg		250.00
			$	2,010.00

ID: 0010371

SUPPLEMENTAL INFORMATION

OTHER REVENUE DETAIL - PAGE 19, LINE 28a

MISCELLANEOUS INCOME	4,635
TOTAL	4,635

OTHER EXPENSES - PAGE 3, LINE 15

NURSING HOME TAX	114,332
TOTAL	114,332

RECLASSES - PAGE 3

COSTS OF EMPLOYEE MEALS RECLASSED:

FROM COL 2, LINE ----->	2	(36,978)
TO COL 3, LINE ----->	22	36,978

NURSE AIDE TRAINING - PAGE 15

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