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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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) 897-6947 **Fax #** (630) 897-6949

HFS ID Number:

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

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(c)(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: CATHY FLANAGAN **Telephone Number:** (630) 897-6947
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 07/01/2016 to 06/30/2017 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: 07/01/2016 Ending: 06/30/2017

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	12	Skilled (SNF)	12	4,380	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,520	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	4,369			4,369	8
9	SNF/PED					9
10	ICF		16,108		16,108	10
11	ICF/DD					11
12	SC		30,161		30,161	12
13	DD 16 OR LESS					13
14	TOTALS	4,369	46,269		50,638	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.11%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 [X] NO [ ]

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: 07/01/2016 Ending: 06/30/2017

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	345,596	10,071	11,556	367,223		367,223		367,223			1
2	Food Purchase		358,340		358,340	(57,945)	300,395	(8,844)	291,551			2
3	Housekeeping	78,764	37,535	34,018	150,317		150,317		150,317			3
4	Laundry	20,311		3,643	23,954		23,954		23,954			4
5	Heat and Other Utilities			132,615	132,615		132,615		132,615			5
6	Maintenance	111,950	14,805	62,193	188,948		188,948		188,948			6
7	Other (specify):*											7
8	TOTAL General Services	556,621	420,751	244,025	1,221,397	(57,945)	1,163,452	(8,844)	1,154,608			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,443,798	73,258	71,659	1,588,715		1,588,715		1,588,715			10
10a	Therapy											10a
11	Activities	158,583	4,244	580	163,407		163,407		163,407			11
12	Social Services	45,361		886	46,247		46,247		46,247			12
13	CNA Training											13
14	Program Transportation			6,145	6,145		6,145	(1,210)	4,935			14
15	Other (specify):*			124,222	124,222		124,222		124,222			15
16	TOTAL Health Care and Programs	1,647,742	77,502	203,492	1,928,736		1,928,736	(1,210)	1,927,526			16
	C. General Administration											
17	Administrative	94,114			94,114		94,114		94,114			17
18	Directors Fees											18
19	Professional Services			25,339	25,339		25,339		25,339			19
20	Dues, Fees, Subscriptions & Promotions			19,986	19,986		19,986	(17,599)	2,387			20
21	Clerical & General Office Expenses	111,833	12,497	70,877	195,207		195,207	(2,470)	192,737			21
22	Employee Benefits & Payroll Taxes			437,665	437,665	57,945	495,610		495,610			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,090	2,090		2,090		2,090			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			97,542	97,542		97,542		97,542			26
27	Other (specify):*											27
28	TOTAL General Administration	205,947	12,497	653,499	871,943	57,945	929,888	(20,069)	909,819			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,410,310	510,750	1,101,016	4,022,076		4,022,076	(30,123)	3,991,953			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:** 07/01/2016 **Ending:** 06/30/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			117,859	117,859		117,859		117,859			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			117,859	117,859		117,859		117,859			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)**	2,410,310	510,750	1,251,725	4,172,785		4,172,785	(30,123)	4,142,662			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: 07/01/2016 Ending: 06/30/2017

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	(8,844)	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)	(1,210)	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	(4,994)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(12,605)	20		28
29	Other-Attach Schedule INVESTMENT FEES	(2,470)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,123)		$	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))**	$ (30,123)		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: 07/01/2016

Ending: 06/30/2017

	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:** 07/01/2016 **Ending:** 06/30/2017

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,844)	0	0	0	0	0	0	0	0	0	0	(8,844)	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**	(8,844)	0	0	0	0	0	0	0	0	0	0	(8,844)	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	(1,210)	0	0	0	0	0	0	0	0	0	0	(1,210)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,210)	0	0	0	0	0	0	0	0	0	0	(1,210)	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	(17,599)	0	0	0	0	0	0	0	0	0	0	(17,599)	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**	(17,599)	0	0	0	0	0	0	0	0	0	0	(17,599)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,653)	0	0	0	0	0	0	0	0	0	0	(27,653)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number JENNINGS TERRACE **#** 0010371 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

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)**	(27,653)	0	0	0	0	0	0	0	0	0	0	(27,653)	45

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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

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

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	DUANNE KLECKNER	BOD						1
2	JONATHAN BIERITZ	BOD						2
3	DOUGLAS CHEATHAM	BOD						3
4	JESS TOISSANT	BOD						4
5	JOE JACOBS	BOD						5
6	LYNN AKERS	BOD						6
7	TIM MCCANN	BOD						7
8	MOLLIE MILLEN	BOD						8
9	MICHAEL MARZEC	BOD						9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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: 07/01/2016 Ending: 6/30/2017

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: 07/01/2016 Ending: 06/30/2017

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:** 07/01/2016 **Ending:** 06/30/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:			
	2012		8
	2013		9
	2014		10
	2015		11
	2016		12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 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 2016 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 2016.

	(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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 07/01/2016 Ending: 06/30/2017

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: 07/01/2016 Ending: 06/30/2017

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		1,474,978	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		2,974	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			1996	98,189		VAR			98,189	15
16	BUILDING IMPROVEMENT			1998	3,243		10			3,243	16
17	BUILDING IMPROVEMENT			1999	8,049	322	40	322		4,863	17
18	BUILDING IMPROVEMENT			2000	52,261	2,090	40	2,090		30,448	18
19	BUILDING IMPROVEMENT			2001	11,027	334	VAR	334		7,470	19
20	BUILDING IMPROVEMENT			2002	14,456		VAR			14,456	20
21	BUILDING IMPROVEMENT			2003	7,541		VAR			7,541	21
22	BUILDING IMPROVEMENT			2005	13,050		10			13,050	22
23	BUILDING IMPROVEMENT			2006	7,157		VAR			7,157	23
24	BUILDING IMPROVEMENT			2007	24,900		10			24,900	24
25	BUILDING IMPROVEMENT			2008	59,940	4,510	VAR	4,510		42,844	25
26	BUILDING IMPROVEMENT			2009	15,332	1,533	10	1,533		13,798	26
27	BUILDING IMPROVEMENT			2010	9,033		5			9,033	27
28	BUILDING IMPROVEMENT			2011	48,839	4,183	VAR	4,183		27,190	28
29	BUILDING IMPROVEMENT			2012	98,850	7,418	VAR	7,418		43,638	29
30	BUILDING IMPROVEMENT			2013	4,000	400	10	400		1,800	30
31	BUILDING IMPROVEMENT - NEW FLOORING ANNEX			2014	41,170	4,117	10	4,117		14,409	31
32	BUILDING IMPROVEMENT - NEW FLOORING ANNEX			2015	55,173	5,517	10	5,517		13,793	32
33	BUILDING IMPROVEMENT - GENERATOR			2016	38,037	3,804	10	3,804		5,706	33
34	BUILDING IMPROVEMENT - COOLING TOWER			2016	28,175	1,878	15	1,878		2,818	34
35	BUILDING IMPROVEMENT - NURSES STATION			2016	2,895	579	5	579		869	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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 - ROOF	2017	$ 42,086	$ 2,104	10	$ 2,104	$	$ 2,104	37
38	BUILDING IMPROVEMENT - KITCHEN FLOORING	2017	13,000	650	10	650		650	38
39	BUILDING IMPROVEMENT - PAVILLION CONCRETE	2017	5,418	271	10	271		271	39
40	BUILDING IMPROVEMENT - WINDOWS, ICF RES ROOMS	2017	6,775	339	10	339		339	40
41	BUILDING IMPROVEMENT - CHILLER PUMP	2017	6,393	320	10	320		320	41
42	BUILDING IMPROVEMENT - GAZEBO	2017	4,320	216	10	216		216	42
43	LAND IMP - PARKING LOT	1974	470		7			470	43
44	LAND IMP - PARKING LOT	1985	880		7			880	44
45	LAND IMP - PARKING LOT	1992	7,445		10			7,445	45
46	LAND IMP - PARKING LOT - BLACKTOP	2001	7,549		10			7,549	46
47	LAND IMP - PARKING LOT - FRONT ENTRANCE	2003	30,959		10			30,959	47
48	LAND IMP - PARKING LOT - LIGHTS	2010	3,518	352	10	352		2,640	48
49	LAND IMP - PARKING LOT - RESURFACE	2013	6,389	639	10	639		2,875	49
50	LAND IMP - VARIOUS	1978	2,317		10			2,317	50
51	LAND IMP - VARIOUS	1982	1,007		10			1,007	51
52	LAND IMP - VARIOUS	1988	4,084		10			4,084	52
53	LAND IMP - YARD LIGHTS	1989	1,390		15			1,390	53
54	LAND IMP - SIDEWALK	1990	1,450		10			1,450	54
55	LAND IMP - SIDEWALK	1991	600		10			600	55
56	LAND IMP - SIDEWALK	1994	440		15			440	56
57	LAND IMP - SIDEWALK	1998	1,592		10			1,592	57
58	LAND IMP - SIDEWALK	2002	225		10			225	58
59	LAND IMP - FENCE	2003	3,581		10			3,581	59
60	LAND IMP - FENCE	2004	4,353		10			4,353	60
61	LAND IMP - TREE REMOVAL / CONCRETE	2005	15,812		10			15,812	61
62	LAND IMP - TERRACE	2010	35,935	2,396	15	2,396		17,968	62
63	LAND IMP - CONCRETE WORK	2011	3,332	333	10	333		2,331	63
64	LAND IMP - EASTSIDE ENTRY	2014	6,400	640	10	640		2,560	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,390,268	$ 91,632		$ 91,632	$	$ 2,645,315	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: 07/01/2016 Ending: 06/30/2017

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	$ 144,874	$ 17,804	$ 17,804	$		$ 81,646	71
72	Current Year Purchases	132,352	8,423	8,423		7	8,423	72
73	Fully Depreciated Assets	812,752					812,752	73
74								74
75	TOTALS	$ 1,089,978	$ 26,227	$ 26,227	$		$ 902,821	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)	$ 5,103,643	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 117,859	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 117,859	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)	$ 3,596,627	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: 07/01/2016 Ending: 06/30/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: 07/01/2016 Ending: 06/30/2017

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.

Facility Name & ID Number JENNINGS TERRACE

STATE OF ILLINOIS
0010371 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): THIS SCHEDULE IS N/A									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number JENNINGS TERRACE **#** 0010371 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2017 **(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	$ 850,883	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 69,000)	147,297		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,146		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,030,326	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,906,950		12
13	Land	574,906		13
14	Buildings, at Historical Cost	3,390,268		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,138,469		16
17	Accumulated Depreciation (book methods)	(3,596,627)		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)**	$ 3,413,966	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,444,292	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 76,875	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,692		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,448		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	142,200		36
37	NURSING HOME TAX PAYABLE	41,585		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 389,800	$	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)**	$ 389,800	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,054,492	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,444,292	$	48

***(See instructions.)**

Facility Name & ID Number JENNINGS TERRACE # 0010371 **Report Period Beginning:** 07/01/2016 **Ending:** 06/30/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,789,157	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,789,157	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	265,335	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)**	$ 265,335	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)**	$ 4,054,492	24 *

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

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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	$ 4,381,047	1
2	Discounts and Allowances for all Levels	(19,250)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,361,797	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	2,132	13
14	Non-Patient Meals	8,844	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)**	$ 10,976	23
	D. Non-Operating Revenue		
24	Contributions	59,292	24
25	Interest and Other Investment Income***	(377)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 58,915	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	TRANSPORTATION INCOME	1,210	28
28a	OTHER INCOME	5,222	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,432	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,438,120	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,221,397	31
32	Health Care	1,928,736	32
33	General Administration	871,943	33
	B. Capital Expense		
34	Ownership	117,859	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)***	$ 4,172,785	40
41	**Income before Income Taxes (line 30 minus line 40)****	265,335	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 265,335	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 547,453	44
45	Private Pay - Net Inpatient Revenue	3,814,344	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)	$ 4,361,797	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: 07/01/2016 Ending: 06/30/2017

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	1,954	1,954	$ 71,174	$ 36.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,461	7,785	175,772	22.58	3
4	Licensed Practical Nurses	15,314	15,700	337,981	21.53	4
5	CNAs & Orderlies	55,216	56,202	733,724	13.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,160	4,230	50,341	11.90	8
9	Activity Director	2,969	3,293	68,361	20.76	9
10	Activity Assistants	7,153	7,600	90,222	11.87	10
11	Social Service Workers	1,862	1,935	45,361	23.44	11
12	Dietician					12
13	Food Service Supervisor	1,956	2,202	45,357	20.60	13
14	Head Cook	6,561	6,841	97,888	14.31	14
15	Cook Helpers/Assistants	21,526	22,165	202,351	9.13	15
16	Dishwashers					16
17	Maintenance Workers	5,284	5,709	111,950	19.61	17
18	Housekeepers	8,661	8,814	78,764	8.94	18
19	Laundry	1,989	2,195	20,311	9.25	19
20	Administrator	2,094	2,094	94,114	44.94	20
21	Assistant Administrator					21
22	Other Administrative	4,054	4,246	111,833	26.34	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	1,885	2,097	24,752	11.80	31
32	Other Health Care(specify)					32
33	Other(specify) NURSE AIDES	6,000	6,060	50,054	8.26	33
34	TOTAL (lines 1 - 33)	156,099	161,122	$ 2,410,310 *	$ 14.96	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	136	$ 7,272	Ln 1, Col 3	35
36	Medical Director				36
37	Medical Records Consultant	13	795	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				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	149	$ 8,067		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	549	$ 26,351	Ln 10, Col 3	50
51	Licensed Practical Nurses	48	1,930	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	597	$ 28,281		53

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CATHY FLANAGAN	EXEC DIRECTOR	NONE	$ 94,114
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,114

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
WEBER & ASSOCIATES	ACCOUNTING	$ 12,000
SLUPIK AND ASSOCIATES	AUDIT / CONSULT	11,869
DREYER FOOTE ETAL	LEGAL	1,470
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 25,339

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,024
Unemployment Compensation Insurance	28,736
FICA Taxes	186,160
Employee Health Insurance	171,220
Employee Meals	57,945
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE INCENTIVES	4,757
OTHER	2,768
TOTAL (agree to Schedule V, line 22, col.8)	$ 495,610

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

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 6)	110
Patient Background Checks 36	640
ADVERTISING	17,599
DUES & SUBSCRIPTIONS	1,637
Less: Public Relations Expense	( )
Non-allowable advertising	(4,994)
Yellow page advertising	(12,605)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,387

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,090
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,090

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 07/01/2016 Ending: 06/30/2017

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.

(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. $ **57,945** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **8,844**

(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 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 6/30/2017
ID: 0010371
LISTING OF LEGAL FEES

07/31/2016	15904-0008M	Law Firm of Dreyer, Foote, Streit, Furg	$ 160.00
07/31/2016	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	150.00
10/01/2016	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	100.00
11/30/2016	15904-00M	Law Firm of Dreyer, Foote, Streit, Furg	300.00
11/30/2016	15904-008M	Law Firm of Dreyer, Foote, Streit, Furg	100.00
02/28/2017	15904-008M	Law Firm of Dreyer, Foote, Streit, Furg	100.00
04/30/2017	15904-017M	Law Firm of Dreyer, Foote, Streit, Furg	110.00
04/30/2017	15904-018M	Law Firm of Dreyer, Foote, Streit, Furg	110.00
05/31/2017	15904-00M	Law Firm of Dreyer, Foote, Streit, Furg	290.00
05/31/2017	15904-018M	Law Firm of Dreyer, Foote, Streit, Furg	50.00
			$ 1,470.00

JENNINGS TERRACE INC COST REPORT FOR 6/30/2017
ID: 0010371
SUPPLEMENTAL INFORMATION

OTHER REVENUE DETAIL - PAGE 19, LINE 28a

MISCELLANEOUS INCOME	5,222
TOTAL	5,222

OTHER EXPENSES - PAGE 3, LINE 15

NURSING HOME TAX	124,222
TOTAL	124,222

RECLASSES - PAGE 3

COSTS OF EMPLOYEE MEALS RECLASSED:

FROM COL 2, LINE ----->	2	(57,945)
TO COL 3, LINE ----->	22	57,945

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
EXECUTIVE DIRECTOR	3/8/2017	EAST PEORIA, IL	Takes More Than Money To Be Successful	INHAA	95.00
ACTIVITY DIRECTOR	10/20/2016	PALATINE, IL	Activity Director - 36 Hour Training	William Rainey Harper College	750.00
ENVIRONMENTAL SERVICE	11/29/2016	SCHAUMBURG, IL	Survey Enforcement of New Life Safety Code	HIN	199.00
SOCIAL SERVICE DIRECTOR	12/1/2016	DOWNERS GROVE, IL	The Power of Residual Memory: Therapeutic Approaches to Dimentia	INHAA	210.00
WAHID WARD	4/27/2017	GALESBURG, IL	RNA Training	AZER	112.00
VARIOUS DIRECTORS	5/17/2017	ITASCA, IL	Undisturbed Sleep at Night-A Key to Fall Reduction and Overall Good Health	IL Pioneer Coalition	724.00
					2,090.00