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.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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:

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

In the event there are further questions about this report, please contact:
Name: David M Underwood **Telephone Number:** (309)8237135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2019 to 6/30/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David M Underwood
(Title) EVP & CFO

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 _____

	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	4,392	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5	103	Sheltered Care (SC)	103	37,698	5
6		ICF/DD 16 or Less			6
7	163	TOTALS	163	59,658	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,668			5,668	8
9	SNF/PED					9
10	ICF		12,693		12,693	10
11	ICF/DD					11
12	SC			30,472	30,472	12
13	DD 16 OR LESS					13
14	TOTALS	5,668	12,693	30,472	48,833	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.85%

D. How many bed reserve days during this year were paid by the Department?
None (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? Yes

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

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

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 [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [xx] If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	397,853	14,135	18,083	430,071		430,071		430,071			1
2	Food Purchase		352,526		352,526		352,526		352,526			2
3	Housekeeping	79,761	18,239		98,000		98,000		98,000			3
4	Laundry	53,551	3,474		57,025		57,025		57,025			4
5	Heat and Other Utilities			135,607	135,607		135,607		135,607			5
6	Maintenance	94,924	66,169	126,348	287,441		287,441		287,441			6
7	Other (specify):*											7
8	TOTAL General Services	626,089	454,543	280,038	1,360,670		1,360,670		1,360,670			8
	B. Health Care and Programs											
9	Medical Director			325	325		325		325			9
10	Nursing and Medical Records	1,533,462	87,185	75,724	1,696,371		1,696,371		1,696,371			10
10a	Therapy		6,121		6,121	(6,121)						10a
11	Activities	87,486	5,272		92,758		92,758		92,758			11
12	Social Services	81,172		2,107	83,279		83,279		83,279			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,702,120	98,578	78,156	1,878,854	(6,121)	1,872,733		1,872,733			16
	C. General Administration											
17	Administrative	110,978			110,978		110,978		110,978			17
18	Directors Fees											18
19	Professional Services			245,252	245,252		245,252	(5,350)	239,902			19
20	Dues, Fees, Subscriptions & Promotions			159,236	159,236	(145,672)	13,564	(3,778)	9,786			20
21	Clerical & General Office Expenses	176,849	23,769	11,375	211,993		211,993		211,993			21
22	Employee Benefits & Payroll Taxes			471,826	471,826		471,826		471,826			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,931	2,931		2,931		2,931			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			138,008	138,008		138,008		138,008			26
27	Other (specify):*											27
28	TOTAL General Administration	287,827	23,769	1,028,628	1,340,224	(145,672)	1,194,552	(9,128)	1,185,424			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,616,036	576,890	1,386,822	4,579,748	(151,793)	4,427,955	(9,128)	4,418,827			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Jennings Terrace #0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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			120,000	120,000		120,000		120,000			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,146	1,146		1,146	(1,146)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,696	35,696		35,696		35,696			35
36	Other (specify):*											36
37	**TOTAL Ownership**			156,842	156,842		156,842	(1,146)	155,696			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					6,121	6,121		6,121			39
40	Barber and Beauty Shops		52	4,645	4,697		4,697		4,697			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					145,672	145,672		145,672			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		52	4,645	4,697	151,793	156,490		156,490			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,616,036	576,942	1,548,309	4,741,287		4,741,287	(10,274)	4,731,013			45

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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				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	(1,146)			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)				16
17	Non-Care Related Fees	(204)			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	(5,350)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,574)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,274)		$	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))**	$ (10,274)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Jennings Terrace

ID# 0010371

Report Period Beginning: 7/1/2019

Ending: 6/30/2020

	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		(5,350)	19	11
12		(1,146)	32	12
13		0	27	13
14		(3,574)	20	14
15		(204)	20	15
16		0	27	16
17		0	24	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	(10,274)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	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	(5,350)	0	0	0	0	0	0	0	0	0	0	(5,350)	19
20	Fees, Subscriptions & Promotions	(3,778)	0	0	0	0	0	0	0	0	0	0	(3,778)	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**	(9,128)	0	0	0	0	0	0	0	0	0	0	(9,128)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,128)	0	0	0	0	0	0	0	0	0	0	(9,128)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jennings Terrace **#** 0010371 **Report Period Beginning:** 7/1/2019 **Ending:** 6/30/2020

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	(1,146)	0	0	0	0	0	0	0	0	0	0	(1,146)	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**	(1,146)	0	0	0	0	0	0	0	0	0	0	(1,146)	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)**	(10,274)	0	0	0	0	0	0	0	0	0	0	(10,274)	45

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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
Board of Directors List Attached						
(Not for profit Board-No individual						
ownership)						

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 [xx] NO

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

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	Board Members are not compensated				0	0			$ 0		1
2	for their services										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [xx]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Old Second National Bank		xx								1,146	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 1,146	9
	B. Non-Facility Related*											
10	Interest Income										(1,146)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,146)	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. $ None Line #

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

Not for profit - no real estate taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.

2019 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 2019 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 2019.

	(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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	475,304	Various	$ 574,906	1
2					2
3	TOTALS	475,304		$ 574,906	3

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	$		$	$	$	4
5	60		1985	1985	1,863,135						5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENT			1967	34,983						9
10	BUILDING IMPROVEMENT			1968	8,760						10
11	BUILDING IMPROVEMENT			1990	4,376						11
12	BUILDING IMPROVEMENT			1992	4,550						12
13	BUILDING IMPROVEMENT			1993	7,238						13
14	BUILDING IMPROVEMENT			1994	4,677						14
15	BUILDING IMPROVEMENT			1996	98,189						15
16	BUILDING IMPROVEMENT			1998	3,243						16
17	BUILDING IMPROVEMENT			1999	8,049						17
18	BUILDING IMPROVEMENT			2000	52,261						18
19	BUILDING IMPROVEMENT			2001	11,027						19
20	BUILDING IMPROVEMENT			2002	14,456						20
21	BUILDING IMPROVEMENT			2003	7,541						21
22	BUILDING IMPROVEMENT			2005	13,050						22
23	BUILDING IMPROVEMENT			2006	7,157						23
24	BUILDING IMPROVEMENT			2007	24,900						24
25	BUILDING IMPROVEMENT			2008	59,940						25
26	BUILDING IMPROVEMENT			2009	15,332						26
27	BUILDING IMPROVEMENT			2010	9,033						27
28	BUILDING IMPROVEMENT			2011	48,839						28
29	BUILDING IMPROVEMENT			2012	98,850						29
30	BUILDING IMPROVEMENT			2013	4,000						30
31	BUILDING IMPROVEMENT			2014	41,170						31
32	BUILDING IMPROVEMENT - NEW FLOORING ANNEX			2015	55,173						32
33	BUILDING IMPROVEMENT - GENERATOR			2016	38,037						33
34	BUILDING IMPROVEMENT - COOLING TOWER			2016	28,175						34
35	Book Depreciation					89,760		89,760			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: 7/1/2019 Ending: 6/30/2020

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 - NURSES STATION	2016	$ 2,895	$		$	$	$	37
38	BUILDING IMPROVEMENT- ROOF	2017	42,086						38
39	BUILDING IMPROVEMENT- KITCHEN FLOORING	2017	13,000						39
40	BUILDING IMPROVEMENT- PAVILLION CONCRETE	2017	5,418						40
41	BUILDING IMPROVEMENT- WINDOWS, ICF RES ROOMS	2017	6,775						41
42	BUILDING IMPROVEMENT- CHILLER PUMP	2017	6,393						42
43	BUILDING IMPROVEMENT-GAZEBO	2017	4,320						43
44	BUILDING IMPROVEMENT-SPRINKLER SYSTEM, NURSIN	2018	6,533						44
45	BUILDING IMPROVEMENT- WINDOW TREATMENTS, SC	2018	10,000						45
46	BUILDING IMPROVEMENT-PAINTING, SHELTERED CARE	2018	30,080						46
47	BUILDING IMPROVEMENT-ASBESTOS REMOVAL, SC	2018	50,480						47
48	BUILDING IMPROVEMENT - FLOORING, ENTIRE BUILDIN	2018	121,371						48
49	BUILDING IMPROVEMENT- ELECTRICAL UPGRADES, EN	2018	66,666						49
50	BUILDING IMPROVEMENT- BOILER	2018	14,669						50
51	BUILDING IMPROVEMENT- DUMBWAITER, SHELTERED C	2018	2,500						51
52	LAND IMP -PARKING LOT	1974	470						52
53	LAND IMP - PARKING LOT	1985	880						53
54	LAND IMP - PARKING LOT	1992	7,445						54
55	LAND IMP - PARKING LOT - BLACKTOP	2001	7,549						55
56	LAND IMP - PARKING LOT - FRONT ENTRANCE	2003	30,959						56
57	LAND IMP - PARKING LOT - LIGHTS	2010	3,518						57
58	LAND IMP - PARKING LOT - RESURFACE	2013	6,389						58
59	LAND IMP - VARIOUS	1978	2,317						59
60	LAND IMP - VARIOUS	1982	1,007						60
61	LAND IMP - VARIOUS	1988	4,084						61
62	LAND IMP - YARD LIGHTS	1989	1,390						62
63	LAND IMP - SIDEWALK	1990	1,450						63
64	LAND IMP - SIDEWALK	1991	600						64
65	LAND IMP - SIDEWALK	1994	440						65
66	LAND IMP - SIDEWALK	1998	1,592						66
67	LAND IMP - SIDEWALK	2002	225						67
68	LAND IMP - FENCE	2003	3,581						68
69	LAND IMP - FENCE	2004	4,353						69
70	TOTAL (lines 4 thru 69)		$ 3,631,088	$ 89,760		$ 89,760	$	$	70

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	
1	Totals from Page 12A, Carried Forward		$ 3,631,088	$ 89,760		$ 89,760	$	$	1
2	LAND IMP - TREE REMOVAL / CONCRETE	2005	15,812						2
3	LAND IMP - TERRACE	2010	35,935						3
4	LAND IMP - CONCRETE WORK	2011	3,332						4
5	LAND IMP - EASTSIDE ENTRY	2014	6,400						5
6	LAND IMP - LANDSCAPING, ENTIRE FACILITY	2018	9,165						6
7	BUILDING IMP- AIR HANDLER	2019	14,895						7
8	BUILDING IMP- DUMBWAITER	2019	30,706						8
9	BUILDING IMP- INSTALLED CARPET AND VINYL PLANKS	2019	20,151						9
10	IN TWELVE RESIDENT ROOMS (ALL DOUBLES)								10
11	BUILDING IMP- SIGN	2019	20,740						11
12	BUILDING IMP- WATER HEATERS	2019	5,000						12
13	BUILDING IMP- GARAGE / BOOSTER HEATER	2019	4,225						13
14	BUILDING IMP- INSTALL NEW CARPET SQUARES	2019	9,150						14
15	IN THE MAIN ENTRANCE LOBBY								15
16									16
17	Upgrade automatic fire sprinkler system	2020	9,185						17
18	Complete Laundry dumbwaiter installation	2020	26,295						18
19	Replace flooring - lobby and dining room	2020	12,307						19
20	Replace chemical injection pump - water system	2020	3,895						20
21	Rebuild pump - boiler	2020	3,685						21
22	Install 100 ton air cooled chiller	2020	8,718						22
23	Install mini-split (indoor and outdoor units)cooling system	2020	5,515						23
24	for food prep room								24
25	Install new fire alarm system and applicable devices	2020	24,375						25
26	Install new HVAC units - kitchen and dining room	2020	26,975						26
27	Replace refrigerant system - walk-in cooler	2020	5,444						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,932,993	$ 89,760		$ 89,760	$	$	34

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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	$ 1,230,582	$ 30,240	$ 30,240	$		$	71
72	Current Year Purchases	51,740						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,282,322	$ 30,240	$ 30,240	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 5,790,221	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 120,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 120,000	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)	$	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 35,696 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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 ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 0	$		$	1
2	Licensed Speech and Language Development Therapist		hrs			0				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			0	0			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				6,121		6,121	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					0				13
14	TOTAL			$		$	$ 6,121		$ 6,121	14

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

STATE OF ILLINOIS

Facility Name & ID Number Jennings Terrace **#** 0010371 **Report Period Beginning:** 7/1/2019 **Ending:** 6/30/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2020 **(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	$ 2,451,502	$	1
2	Cash-Patient Deposits	1,374		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(101,288)		3
4	Supply Inventory (priced at FIFO)	20,181		4
5	Short-Term Investments			5
6	Prepaid Insurance	46,770		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)**	$ 2,418,539	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	730,043		13
14	Buildings, at Historical Cost	3,798,827		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,340,651		16
17	Accumulated Depreciation (book methods)	(3,967,657)		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)**	$ 1,901,864	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,320,403	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 197,016	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,394		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,369		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,417		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	Bed Tax	10,374		36
37	Deferred Stimulus Revenue	100,000		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 526,570	$	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)**	$ 526,570	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,793,833	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,320,403	$	48

***(See instructions.)**

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,146,918	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,146,918	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(353,085)	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)**	$ (353,085)	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)**	$ 3,793,833	24 *

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

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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	$ 4,389,000	1
2	Discounts and Allowances for all Levels	(1,916)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,387,084	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	4,643	13
14	Non-Patient Meals		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	15,507	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 20,150	23
	D. Non-Operating Revenue		
24	Contributions	37,478	24
25	Interest and Other Investment Income***	66,891	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 104,369	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Net realized/unrealized investment loss**	(123,401)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (123,401)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,388,202	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,360,670	31
32	Health Care	1,878,854	32
33	General Administration	1,340,224	33
	B. Capital Expense		
34	Ownership	156,842	34
	C. Ancillary Expense		
35	Special Cost Centers	4,697	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,741,287	40
41	**Income before Income Taxes (line 30 minus line 40)****	(353,085)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (353,085)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		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)	$	49

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

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

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

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

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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	3,802	4,045	$ 143,655	$ 35.51	1
2	Assistant Director of Nursing	419	446	18,514	41.51	2
3	Registered Nurses	8,364	8,898	287,587	32.32	3
4	Licensed Practical Nurses	8,496	9,038	261,504	28.93	4
5	CNAs & Orderlies	47,794	50,845	780,380	15.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,978	2,104	41,822	19.88	8
9	Activity Director					9
10	Activity Assistants	5,430	5,777	87,486	15.14	10
11	Social Service Workers	3,268	3,477	81,172	23.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,791	29,565	397,853	13.46	15
16	Dishwashers					16
17	Maintenance Workers	4,410	4,691	94,924	20.24	17
18	Housekeepers	6,013	6,397	79,761	12.47	18
19	Laundry	3,264	3,472	53,551	15.42	19
20	Administrator	1,955	2,080	110,978	53.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,807	7,242	176,849	24.42	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,791	138,077	$ 2,616,036 *	$ 18.95	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		$ 18,083	Ln 1 Col 3	35
36	Medical Director		325	Ln 18 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,874	Ln 10 Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,107	Ln 22 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,389		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 46,314	Ln10 Col 3	50
51	Licensed Practical Nurses		17,812	Ln10 Col 3	51
52	Certified Nurse Assistants/Aides		6,602	Ln10 Col 3	52
53	TOTAL (lines 50 - 52)		$ 70,728		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristen Hendricks	Administrator	None	$ 110,978
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,978

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Management	$ 210,325
A Place For Mom	Resident referrals	1,966
Old Second Nat'l Bank	Investment fees	16,812
Weber & Associates	Bookkeeping services	1,175
Dugan & Lopatka	Audit and Tax services	4,900
First Class Solutions	Medical records consulting	247
Tracye Young	MDS consulting	4,100
ADP	Payroll tax reporting	377
Legal adj to Zero		5,350
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 245,252

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,038
Unemployment Compensation Insurance	40,064
FICA Taxes	200,127
Employee Health Insurance	154,413
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	19,184
TOTAL (agree to Schedule V, line 22, col.8)	$ 471,826

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,052
Health Care Worker Background Check	
(Indicate # of checks performed)	843
Patient Background Checks	
	3,574
	204
	3,891
Less: Public Relations Expense	(3,574)
Non-allowable advertising	(204)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,786

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,599
	122
Seminar Expense	1,210
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,931

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

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. **NA**

(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? **NA**

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **145,672**
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? **Yes**

(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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **4,048**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
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? **NA**
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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Dugan & Lopatka**

(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. **None Claimed**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Line #	Adjustment Amount	
1009			PETTY CASH	2,451,502						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	-101,288						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1135			ACCOUNTS RECEIVABLE-IC							
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	46,770						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY	20,181						
1310			SUPPLIES INVENTORY							
1409			LAND	0						
1450			FURNITURE & EQUIPMENT	1,340,651						
1460			ACCUM DEPR-FURN & EQUIP	0						
1475			BUILDING & IMPROVEMENTS	3,798,827						
1490			ACCUM DEPR-BUILDING	-3,967,657						
1530			RESIDENT FUNDS	1,374						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	0						
2010			ACCOUNTS PAYABLE	-197,016						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-122,402						
2110			ACCRUED VACATION PAY	-84,967						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-10,417	-10,417					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABLI	0						
2310			DEFERRED STIMULUS	-100,000						
2320			IPA PAYMENTS PAYABLE	-10,374						
2350			REAL ESTATE TAX PAYABLE	0						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS							
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED INC EMP & MEM							
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-1,394						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-4,146,918						
2970			PROFIT/LOSS FOR PERIOD	353,085						
3007.1			PATIENT DAYS-PRIVATE	12,693						
3007.2			PATIENT DAYS-IPA	5,668						
3007.3			PATIENT DAYS-MEDICARE	30,472						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-4,330,927		0	0	0	0	
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020		1	BASIC CHARGE-IPA	0		0	0	0	0	
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0	
3035		4	DAY CARE/HOME CARE			0	0	0	0	
3040		1	LIGHT NURSING CARE	0		0	0	0	0	
3050		1	MEDIUM NURSING CARE			0	0	0	0	
3060		1	HEAVY NURSING CARE			0	0	0	0	
3061		1	SKILLED NURSING CARE							
3080		1	NURSING SUPPLIES-PRIVATE	-42,795		0	0	0	0	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0	
3083		1	NURSING SUPPLIES MED PT B							
3100		17	DRUGS	0		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	0		0	0	0	0	
3111		6	PT-IPA			0	0	0	0	
3112		6	PT-MEDICARE PART A			0	0	0	0	
3113		6	PT-MEDICARE PART B			0	0	0	0	
3130		1	PUBLIC AID ASSESSMENT INC	112,732						
3140		19	LABORATORY INCOME			0	0	0	0	
3150		6	SPEECH/OT-PRIVATE			0	0	0	0	
3151		6	SPEECH/OT-IPA			0	0	0	0	
3152		6	SPEECH/OT-MED PART A			0	0	0	0	
3153		6	SPEECH/OT MED PART B							
3410		2	IPA DISCOUNTS	1,916		0	0	0	0	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2	MEDICARE DISCOUNTS			0	0	0	0	
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0	
3520		16	RENT INCOME	0		6	0	6	0	
3530		13	BEAUTY SHOP	-4,643		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	-1,620		0	0	0	0	
3580		12	MANAGEMENT FEES			0	0	0	0	
3590		1	EQUIPMENT RENTAL	-15,278		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	-8,361		0	0	0	0	
3600		21	MISC INCOME	-5,526		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	167,519	176,849	21	1	17	0	
4111			ADMINISTRATOR WAGES	110,978	110,978	17	1	0	0	
4115			VACATION & SICK - G&A	9,330		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	19,184	471,826	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130			EMPLOYEE SCHOLARSHIP W/	0	112,732	21	1	0	0	
4135			EMPLOYEE SCHOLARSHIP CC	0		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	23,769	23,769	21	2	0	0	
4260			TELEPHONE	11,375	11,375	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	0	0	23	3	16	0	**
4280			GENERAL TRAVEL	1,599	2,931	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	122		24	3	19	0	
4285			EDUCATION & SEMINAR	1,210		24	3	19	0	***
4290			HELP WANTED ADVERTISING	5,052	46,504	20	3	0	0	-32,940
4291			PROMOTIONAL ADVERTISING	0		20	3	25	0	
4292			PUBLIC RELATIONS	3,574		20	3	25	-3,574	
4300			LICENSES & FEES	36,831		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	204		20	3	17	-204	
4320			CONTRIBUTIONS	0		27	3	20	0	
4350			PROFESSIONAL FEES	36,117	245,252	19	3	22	-5,350	
4355			MEDICAL DIRECTOR	325	325	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	0		10	3	0	0	
4363			PHARMACIST FEES	4,874		10	3	0	0	
4364			SOC SERV/ACT CONSULT	2,107	2,107	12	3	0	0	
4370			TV RENTAL	11,363		35	3	5	0	
4380			INCOME TAXES		0	27	3	26	0	
4383			BACKGROUND CHECKS	843		20	3	26	0	
4400			PAYROLL TAXES	229,886		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	10,305		22	3	0	0	
4410			GROUP INSURANCE	154,413		22	3	0	0	
4420			LIABILITY INSURANCE	138,008	138,008	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANC	58,038		22	3	0	0	
4450			CENTRAL OFFICE FEES	209,135		19	3	34	0	**
4460			BAD DEBTS	0		27	3	24	0	
4470			LOST ITEMS-RESIDENTS	0		27	3	0		
4490			MISCELLANEOUS	0		27	3	0	0	
4510			REAL ESTATE TAXES	0	0	33	3	0	0	
4600			LEASED EQUIPMENT	24,333	35,696	35	3	16	0	
5110			MAINTENANCE SALARIES	90,587	94,924	6	1	0	0	
5120			MAINTENANCE SICK & VAC	4,337		6	1	0	0	
5130			ELECTRIC	64,773	135,607	5	3	0	0	
5131			NATURAL GAS	31,775		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	39,059		5	3	0	0	
5134			TRASH COLLECTION	17,567	126,348	6	3	0	0	
5140			PROPERTY PLANT REPLACEM	14,329	66,169	6	2	0	0	
5160			GENERAL REPAIR & MAINT	51,840		6	2	0	0	
5165			MAINTENANCE CONTRACTS	108,781		6	3	0	0	
5210			DIETARY WAGES	381,652	397,853	1	1	0	0	
5220			DIETARY SICK & VAC	16,201		1	1	0	0	
5240			DIETARY CONSULTANT	18,083	18,083	2	3	13	0	
5248			FOOD PURCHASES	356,574	352,526	2	2	0	0	
5250			SUPPLIES-DISHWASHING	9,058	14,135	1	2	0	0	
5260			DIETARY REPLACEMENT	4,858		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	219		1	2	0	0	
5295			MEAL CREDIT	-4,048		2	2	0	0	
5310			LAUNDRY WAGES	51,503	53,551	4	1	0	0	
5340			LAUNDRY SICK & VAC	2,048		4	1	0	0	
5370			LAUNDRY REPLACEMENT	472	3,474	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	3,002		4	2	0	0	
5410			HOUSEKEEPING WAGES	76,924	79,761	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	2,837		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	18,239	18,239	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PF	0		3	2	0	0	
6010			RN WAGES-MEDICARE		1,533,462	10	1	0	0	
6020			RN WAGES-NON MEDICARE	272,727		10	1	0	0	
6030			DON WAGES	143,655		10	1	0	0	
6035			ADON	18,514		10	1	0	0	
6040			RN SICK & VACATION	14,860		10	1	0	0	
6110			LPN WAGES-MEDICARE	253,888		10	1	0	0	
6120			LPN WAGES-NON MEDICARE	0		10	1	0	0	
6130			LPN WAGES OTHER			10	1	0	0	
6140			LPN SICK & VACATION	7,616		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	749,429		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	30,951		10	1	0	0	
6245			CONTRACT NURSES-RN	46,314		10	3	0	0	
6246			CONTRACT NURSES-LPN	17,812		10	3	0	0	
6247			CONTRACT NURSES-AIDES	6,602		10	3	0	0	
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0	
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0	
6270			REHAB WAGES	38,965		10	1	0	0	
6275			REHAB SICK & VAC	2,857		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	30,288	87,185	10	2	0	0	
6295			NURSING SUPPLIES	38,101		10	2	0	0	
6390			REPLACEMENT-NURSING	18,796		10	2	0	0	
6490			NURSING OTHER	122	75,724	10	3	0	0	
7280			DRUG PURCHASES	6,121	6,121	39	2	0	0	***
7281			DRUG PURCHASES-OTHER	0		39	2			
7380			LABORATORY SERVICES	0	0	39	3	0	0	
7410			HOME HEALTH SALARY			39	1	0	0	
7440			HOME HEALTH SICK & VAC			39	1	0	0	
7450			HOME HEALTH EXPENSES			39	3	0	0	
7510			ACTIVITES WAGES	84,239	87,486	11	1	0	0	
7540			ACTIVITIES SICK & VAC	3,247		11	1	0	0	
7590			ACTIVITIES SUPPLIES	5,272	5,272	11	2	0	0	
7595			ACTIVITIES FEES	0	0	11	3	0	0	
7610			PT WAGES			39	1	0	0	
7611			PT SICK & VACATION			39	1	0	0	
7620			PT FEES	0	0	39	3	0	0	***
7660			PT SUPPLIES	0		39	2	0	0	
7710			SOCIAL SERVICE WAGES	77,801	81,172	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	3,371		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740			OT FEE	0		39	3	0	0	***
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	0		39	3	0	0	***
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	4,645	4,645	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	52	52	40	2	0	0	
7910			VOLUNTEER COORDINATOR			21	1	0	0	
7940			VOL COORD SICK & VAC			21	1	0	0	
7960			VOL COORD SUPPLIES	0		21	2	0	0	
8100			RENT	0	0	34	3	0	0	
8120			INTEREST EXPENSE	1,146	1,146	32	3	14	-1,146	
8130			DEPRECIATION	120,000	120,000	30	3	9	0	
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510			INTEREST INCOME	-66,891		32	0	10	0	
9520			MISC NON-OPERATING INCOM	85,923		0	0	0	0	
9700			INCOME TAXES	0		0	0	0	0	
				4,647,587	4,741,287					
					93,700					
GRAND TOTALS				353,085					-10,274	
				(NET INCOME)						
				0						
			FACILITY NAME:							
			FACILITY ID:	0						
			FACILITY UNITS:	162						
			BALANCE SHEET TOTAL	-730,043						

1,009	1,009 CASH	2,451,502
1,100	1,100 ACCTS RE	28,712
1,101	1,101 ALLOW. F	(130,000)
1,110	1,110 ACCTS RECEIV-M/C	
1,125	1,125 ACCTS RECEIV-IPA	
1,135	1,135 ACCTS RECEIV-IC	
1,140	1,140 UNAPPLIED CASH RECEIPTS	
1,145	1,145 A/R SUSPENSE-REFUNDS	
1,200	1,200 PREPAID	39,921
1,220	1,220 OTHER PI	6,849
1,300	1,300 DIETARY I	20,181
1,310	1,310 SUPPLIES INVENTORY	
1,320	1,320 LINEN INVENTORY	
1,409	1,409 LAND	730,043
1,450	1,450 FURNITUF	1,340,651
1,460		0
1,475	1,475 BUILDINGS	3,798,827
1,490	1,490 ACCUM DI	(3,967,657)
1,530	1,530 RESIDENT	1,374
1,550	1,550 LOAN FEE	0
1,551	1,551 LOAN FEES ADDED	
1,850	1,850 INTERCOI	0
2,010	2,010 ACCOUNT	(197,016)
2,100	2,095 BONUSES PAYABLE	
2,100	2,100 ACCRUED	(122,402)
2,100	2,100 PR CLEARING-BENEFITS	
2,100	2,100 PR CLEARING-LABOR	
2,110	2,110 ACCRUED	(84,967)
2,120	2,120 U.C. TAXE	(10,417)
2,125	2,125 FICA TAXE	0
2,130	2,130 FEDERAL W/H TAX PAYABLE	
2,140	2,140 STATE W/H TAX PAYABLE	
2,152	2,152 WORKERS COMP ACCRUAL	
2,225	2,225 EMPLOYEEE INSURANCE REFUND	
2,230	2,230 PAYROLL SAVINGS	
2,235	2,240 UNITED FUND	
2,240	2,246 GROUP INSURANCE - CAFETERIA	
2,246	2,250 401K W/H	
2,250		
2,260	2,260 WAGE GA	0
2,300	2,300 ACCRUED	0
2,320	2,320 IPA PAYMI	(10,374)
2,350	2,350 REAL EST	0
2,310	2,310 DEFERRE	(100,000)
2,400	2,400 CURRENT PORTION OF LT DEBT	
2,512	2,512 DUE TO R	(1,394)
2,600	2,600 LOC	0
2,600		0
2,625	2,625 LASALLE CONSTR. LOAN #2	
2,625		
2,695	2,695 CURRENT PORTION OF LT DEBT	
2,720	2,720 RETAINED	(4,146,918)
	net income	353,085
	balance	0

3,007	3,007 PATIENT I	12,693
3,007	3,007 PATIENT I	5,668
3,007	3,007 PATIENT I	30,472
3,007		0
3,007		
3,007		
3,007		
3,010	3,010 BASIC CH	(4,330,927)
3,020	3,020 BASIC CH	0
3,030	3,030 BASIC CH	0
3,040	ASSESSM	112,732
3,050		0
3,060		0
3,061		0
3,080	3,080 NURSING	(42,795)
3,081	3,081 NURSING	0
3,082	3,082 NURSING	0
3,083	3,083 NURSING	0
3,100	3,100 DRUGS-M	0
3,101		0
3,110	3,110 PHYSICAL	0
3,111		0
3,112	3,112 PHYSICAL	0
3,113	3,113 PHYSICAL	0
3,140	3,140 LABORATORY INCOME	
3,150		0
3,151		
3,152	3,152 ST/OT TH	0
3,153	3,153 ST/OT TH	0
3,160	3,185 REHAB/ISOLATION/OTHER CHG	
3,410	3,410 IPA/OTHE	0
3,411	3,411 MEDICARI	0
3,420	3,420 MEDICARI	1,916
3,500		
3,520	3,520 RENT INC	0
3,530	3,530 BEAUTY S	(4,643)
3,560		0
3,570	3,570 VENDING	(1,620)
3,590	3,590 EQUIPMEI	(15,278)
3,595	3,595 RESIDENT	(8,361)
3,600	3,600 MISC INC	(5,526)
4,110	4,110 G&A WAG	167,519
4,111	4,111 ADMINISTI	110,978
4,115	4,115 G&A PTO	9,330
4,120	4,120 EMPLOYE	19,184
4,121		0
4,130	4,130 EMPLOYE	0
4,135	4,135 EMPLOYE	0
4,250	4,250 OFFICE S	7,717
4,255	4,255 POSTAGE	569
4,260	4,260 TELEPHO	11,375
4,275	4,275 TRAINING	0
4,276		0
4,280	4,280 GENERAL	1,599
4,281	4,281 MEAL EXF	122
4,285	4,285 EDUCATI	955
4,289	4,289 MEETINGS	255
4,290	4,290 HELP WAI	5,052
4,291	4,291 PROMOTI	0
4,292	4,292 PUBLIC R	3,574
4,300	4,300 LICENSE	36,831
4,310	4,310 DUES & S	204
4,320	4,320 CONTRIBI	0
4,350	4,350 PROFESS	36,117
4,355	4,355 MEDICAL	325
4,362		0
4,363		4,874
4,364	4,364 SOCIAL S	2,107
4,370	4,370 TV RENTA	11,363
4,383	4,383 BACKGRC	843
4,390	4,390 OTHER T	0
4,400	4,400 PAYROLL	229,886
4,401	4,401 PAYROLL	10,305
4,410	4,410 GROUP IN	154,413
4,420	4,420 LIABILITY	138,008
4,430	4,430 WORKMA	57,311
4,435	4,435 W/C-FIRS	0
4,436	4,436 DRUG TE	727
4,450	4,450 MANAGEN	209,135
4,460	4,460 BAD DEBT	0
4,461	4,461 BAD DEBT	0
4,470	4,470 LOST ITEI	0
4,475	4,475 UNIFORM	0
4,486	4,486 SERVICE	75,104
4,490	4,490 MISC EXP	3,194
4,496	4,496 MISC. M.I.	15,483
4,510	4,510 REAL EST	0
4,600	4,600 LEASED E	24,333
5,110	5,110 MAINTENA	90,587
5,120	5,120 MAINTENA	4,337
5,130	5,130 ELECTRIC	64,773
5,131	5,131 NATURAL	31,775
5,133	5,133 WATER &	39,059
5,134	5,134 TRASH C	17,567
5,140	5,140 PROP/PL	14,329
5,160	5,160 GENERAL	51,840
5,165	5,165 MAINTENA	33,677
5,210	5,210 DIETARY	381,652
5,220	5,220 DIETARY	16,201
5,248	5,248 FOOD PU	353,380
5,250	5,250 SUPPLIES	9,058
5,260	5,260 REPLACE	4,858
5,270	5,270 KITCHEN	219
5,295	5,295 MEAL INC	(4,048)
5,310	5,310 LAUNDRY	51,503
5,340	5,340 LAUNDRY	2,048
5,370	5,370 REPLACE	472
5,230	5,230 DIETARY	18,083
5,390	5,390 LAUNDRY	3,002
5,410	5,410 HOUSEKE	76,924
5,440	5,440 HOUSEKE	2,837
5,480	5,480 SUPPLIES	18,239
5,490	5,490 SUPPLIES	0
6,020	6,020 RN WAGE	272,727
6,030	6,030 DON WAG	143,655
6,035	6,035 ADON WA	18,514
6,040	6,040 RN PTO &	14,860
6,120	6,120 LPN WAG	253,888
6,140	6,140 LPN PTO	7,616
6,220	6,220 AIDES WA	749,429
6,240	6,240 AIDES PT	30,951
6,245	RN CONT	46,314
6,246	LPN CON	17,812
6,247	AIDES CO	6,602
6,250		0
6,255		0
6,260		0
6,270	6,270 REHAB W	38,965
6,275	6,275 REHAB P	2,857
6,290	6,290 NURSING	30,288
6,295	6,295 NURSING	38,101
6,390	6,390 REPLACE	18,796
6,490	6,490 OTHER	122
7,280	7,280 DRUG PU	6,121
7,281	7,281 DRUG PU	0
7,380	7,380 LABORAT	0
7,391	7,390 X-RAY SE	0
7,393		0
7,510	7,510 ACTIVITIE	84,239
7,540	7,540 ACTIVITIE	3,247
7,590	7,590 ACTIVITIE	5,272
7,620	7,620 PHYSICAL	0
7,660	7,660 P.T. SUPF	0
7,710	7,710 SOCIAL S	77,801
7,720	7,720 SOCIAL S	3,371
7,730	7,730 SOCIAL S	0
7,740	7,740 OCCUPAT	0
7,750		
7,770	7,770 SPEECH	0
7,820	7,820 BEAUTICI	4,645
7,890		52
7,960		0
8,120	8,120 INTEREST	1,146
8,125		0
8,130	8,130 DEPRECI	120,000
8,150		0
9,510	9,510 INTEREST	(66,891)
9,520	9,520 MISC NON	85,923
9,530	4,220	0
	8,100	0
	9,702	0
	5,230	0
		353,085

Expenses Fixed Assets

0

Jennings Terrace Inc.
2020 Cost Report
Supplemental Schedules
Reclassification Entries

1. Schedule V - Line 10a to Line 39 - Reclassifications

Line Item		
Purchased Drugs and Medications	$	6,121
Purchased Hospital Services		0
Purchased Laboratory Services		0
Purchased Radiology Services		0
Amount Reclassified to Line 39	$	6,121

2. Schedule V - Line 20 to Line 42 - Reclassification

Line Item		
Provider Participation Fee - $1.50	$	(32,940)
Provider Assesment Fee - $6.07		(112,732)
		(145,672)
Provider Participation Fee		145,672