

Facility Name & ID Number Jennings Terrace, Inc.

0010371 Report Period Beginning: 07/01/05 Ending: 06/30/06

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 N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	8	Skilled (SNF)	8	2,920	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5	103	Sheltered Care (SC)	103	37,595	5
6		ICF/DD 16 or Less			6
7	163	TOTALS	163	59,495	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		465		465	8
9	SNF/PED					9
10	ICF		15,727		15,727	10
11	ICF/DD					11
12	SC		13,561		13,561	12
13	DD 16 OR LESS					13
14	TOTALS		29,753		29,753	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.01%

D. How many bed-hold days during this year were paid by the Department?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
 (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? NO

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

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

I. On what date did you start providing long term care at this location
 Date started 07/15/43

J. Was the facility purchased or leased after January 1, 1978?
 YES Date _____ NO

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS
 ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: JUNE 30 Fiscal Year: JUNE 30
 * All facilities other than governmental must report on the accrual basis

STATE OF ILLINOIS

Facility Name & ID Number Jennings Terrace, Inc. # 0010371 Report Period Beginning: 07/01/05 Ending: 06/30/06

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 OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
A. General Services											
1	Dietary	237,891	13,726	21,237	272,854	(17,527)	255,327		255,327		1
2	Food Purchase		197,214		197,214	(17,800)	179,414	(3,185)	176,229		2
3	Housekeeping	59,747	16,492	19,005	95,244	(4,401)	90,843		90,843		3
4	Laundry	14,284	3,351	1,051	18,686	(1,051)	17,635		17,635		4
5	Heat and Other Utilities			136,890	136,890		136,890		136,890		5
6	Maintenance	72,314		52,793	125,107	(5,321)	119,786		119,786		6
7	Other (specify):*										7
8	TOTAL General Services	384,236	230,783	230,976	845,995	(46,100)	799,895	(3,185)	796,710		8
B. Health Care and Programs											
9	Medical Director			220	220		220		220		9
10	Nursing and Medical Records	929,837	19,908	117,567	1,067,312	(66,885)	1,000,427		1,000,427		10
10a	Therapy										10a
11	Activities	106,775	2,728	7,845	117,348	(7,845)	109,503		109,503		11
12	Social Services	36,450		5,450	41,900	(2,690)	39,210		39,210		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,073,062	22,636	131,082	1,226,780	(77,420)	1,149,360		1,149,360		16
C. General Administration											
17	Administrative	75,487			75,487		75,487		75,487		17
18	Directors Fees										18
19	Professional Services			21,325	21,325		21,325		21,325		19
20	Dues, Fees, Subscriptions & Promotions			57,422	57,422		57,422	(25,234)	32,188		20
21	Clerical & General Office Expense:	59,956	9,925	51,452	121,333	(11,571)	109,762		109,762		21
22	Employee Benefits & Payroll Tax			217,577	217,577	135,091	352,668		352,668		22
23	Inservice Training & Educator										23
24	Travel and Seminar			3,032	3,032		3,032		3,032		24
25	Other Admin. Staff Transportator										25
26	Insurance-Prop.Liab.Malpractice			149,745	149,745		149,745		149,745		26
27	Other (specify):*										27
28	TOTAL General Administration	135,443	9,925	500,553	645,921	123,520	769,441	(25,234)	744,207		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,592,741	263,344	862,611	2,718,696		2,718,696	(28,419)	2,690,277		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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			88,621	88,621		88,621		88,621		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): ³										36
37	TOTAL Ownership			88,621	88,621		88,621		88,621		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportatior										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fec			32,850	32,850		32,850		32,850		42
43	Other (specify): ³										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)	1,592,741	263,344	984,082	2,840,167		2,840,167	(28,419)	2,811,748		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, Inc.

0010371

Report Period Beginning: 07/01/05

Ending: 06/30/06

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals	(3,185)	2		4
5	Telephone, TV & Radio in Resident Room:				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patient:				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income:				10
11	Discounts, Allowances, Rebates & Refund:				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				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer:				22
23	Malpractice Insurance for Individual:				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotions	(22,259)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee:				27
28	Yellow Page Advertising	(2,975)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (28,419)		\$	30

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	2	
		Amount	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 (A) and (B)	\$ (28,419)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport			\$		38
39						39
40	Gift and Coffee Shop:					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Jennings Terrace, Inc.

ID# 0010371

Report Period Beginning: 07/01/05

Ending: 06/30/06

Sch. V Line Reference

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, Inc.

0010371

Report Period Beginning:

07/01/05

Ending:

06/30/06

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	(3,185)	0	0	0	0	0	0	0	0	0	0	(3,185)	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	(3,185)	0	0	0	0	0	0	0	0	0	0	(3,185)	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	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(25,234)	0	0	0	0	0	0	0	0	0	0	(25,234)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(25,234)	0	0	0	0	0	0	0	0	0	0	(25,234)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(28,419)	0	0	0	0	0	0	0	0	0	0	(28,419)	29

Facility Name & ID Number Jennings Terrace, Inc.

0010371

Report Period Beginning:

07/01/05

Ending:

06/30/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
THIS SCHEDULE IS N / A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organizatio	Percent of Ownership	Operating Cost of Related Organization		
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, Inc. # 0010371 Report Period Beginning: 07/01/05 Ending: 06/30/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	THIS SCHEUDLE 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, Inc.

0010371 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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, Inc. # 0010371 Report Period Beginning: 07/01/05 Ending: 06/30/06

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
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)		
	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, Inc.

0010371 Report Period Beginning: 07/01/05 Ending: 06/30/06

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

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																															
1. Real Estate Tax accrual used on 2005 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 2006 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:	<table border="1"> <tr><td>2001</td><td>_____</td><td style="text-align: center;">8</td></tr> <tr><td>2002</td><td>_____</td><td style="text-align: center;">9</td></tr> <tr><td>2003</td><td>_____</td><td style="text-align: center;">10</td></tr> <tr><td>2004</td><td>_____</td><td style="text-align: center;">11</td></tr> <tr><td>2005</td><td>_____</td><td style="text-align: center;">12</td></tr> </table>	2001	_____	8	2002	_____	9	2003	_____	10	2004	_____	11	2005	_____	12	<table border="1"> <tr><td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td></tr> <tr><td style="text-align: center;">13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td><td style="text-align: right;">13</td></tr> <tr><td style="text-align: center;">14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td style="text-align: right;">14</td></tr> <tr><td style="text-align: center;">15</td><td>LESS REFUND FROM LINE 6 \$</td><td style="text-align: right;">15</td></tr> <tr><td style="text-align: center;">16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td style="text-align: right;">16</td></tr> </table>	FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2001	_____	8																													
2002	_____	9																													
2003	_____	10																													
2004	_____	11																													
2005	_____	12																													
FOR BHF USE ONLY																															
13	FROM R. E. TAX STATEMENT FOR 2005 \$	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 o 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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jennings Terrace, Inc. 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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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, Inc.

0010371 Report Period Beginning:

07/01/05 Ending:

06/30/06

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? (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? (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 ground (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 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>11 ACRES</u>	<u>VARIOUS</u>	<u>\$ 574,906</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	#VALUE!		\$ 574,906	3

Facility Name & ID Number Jennings Terrace, Inc.

0010371

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	103		1961	1961	\$ 603,512	\$	40	\$		\$ 603,512	4
5	60		1985	1985	1,863,135	46,578	40	46,578		962,619	5
6											6
7											7
8											8
	Improvement Type**										
9		BUILDING IMPROVEMENT		1967	34,983	875	40	875		34,546	9
10		BUILDING IMPROVEMENT		1968	8,760	219	40	219		8,431	10
11		BUILDING IMPROVEMENT		1990	4,376	109	40	109		1,774	11
12		BUILDING IMPROVEMENT		1992	4,550	129	VAR	129		4,387	12
13		BUILDING IMPROVEMENT		1993	7,238	438	15	438		5,912	13
14		BUILDING IMPROVEMENT		1994	4,677	148	VAR	148		4,382	14
15		BUILDING IMPROVEMENT - ROOF REPAIR		1996	92,951	1,372	VAR	1,372		92,951	15
16		BUILDING IMPROVEMENT		1996	5,238	411	VAR	411		4,765	16
17		BUILDING IMPROVEMENT		1998	3,243	324	10	324		2,648	17
18		BUILDING IMPROVEMENT - RETAINING WALL		1999	8,049	201	40	201		1,442	18
19		BUILDING IMPROVEMENT - RETAINING WALL		2000	8,361	209	40	209		1,289	19
20		BUILDING IMPROVEMENT - HANDICAPPED ENTRY		2000	43,900	1,098	40	1,098		6,951	20
21		BUILDING IMPROVEMENT - RETAINING WALL		2001	8,361	209	40	209		1,254	21
22		BUILDING IMPROVEMENT - WINDOWS		2001	2,666	267	10	267		1,467	22
23		BUILDING IMPROVEMENT - KITCHEN FLOOR / WINDOWS		2002	14,456	893	VAR	893		3,918	23
24		BUILDING IMPROVEMENT - KITCHEN RENOVATION / DOOR		2003	7,541	497	VAR	497		1,875	24
25		BUILDING IMPROVEMENT - MAIN BREAKER		2005	8,900	371	10	371		744	25
26		BUILDING IMPROVEMENT - DOOR / HVAC IMPROVEMENTS		2005	4,150	468	10	468		850	26
27		BUILDING IMPROVEMENT - WATER PIPE / CARPETING		2006	7,157	1,029	VAR	1,029		1,029	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2

See Page 12A, Line 70 for total

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

Facility Name & ID Number Jennings Terrace, Inc.

0010371

Report Period Beginning:

07/01/05

Ending:

06/30/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LAND IMP - PARKING LOT	1974	\$ 470	\$	7	\$	\$ 470	37
38	LAND IMP - PARKING LOT	1985	880		7		880	38
39	LAND IMP - PARKING LOT	1992	7,445		10		7,445	39
40	LAND IMP - PARKING LOT	2001	7,549	756	10	756	4,404	40
41	LAND IMP - PARKING LOT	2003	30,959	3,095	10	3,095	9,881	41
42								42
43								43
44	LAND IMP - VARIOUS	1978	2,317		10		2,317	44
45	LAND IMP - VARIOUS	1982	1,007		10		1,007	45
46	LAND IMP - VARIOUS	1988	4,084		10		4,084	46
47	LAND IMP - YARD LIGHTS	1989	1,390		15		1,390	47
48	LAND IMP - SIDEWALK	1990	1,450		10		1,450	48
49	LAND IMP - SIDEWALK	1991	600		10		600	49
50	LAND IMP - SIDEWALK	1994	440	29	15	29	359	50
51	LAND IMP - SIDEWALK	1998	1,592	159	10	159	1,393	51
52	LAND IMP - SIDEWALK	2002	225	11	20	11	51	52
53	LAND IMP - FENCE	2003	3,581	358	10	358	1,309	53
54	LAND IMP - FENCE	2004	4,353	290	15	290	796	54
55	LAND IMP - TREE REMOVAL / CONCRETE	2005	15,812	553	15	553	1,099	55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$ 2,830,358	\$ 61,096		\$ 61,096	\$ 1,785,681	70

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

Facility Name & ID Number Jennings Terrace, Inc. # 0010371 Report Period Beginning: 07/01/05 Ending: 06/30/06

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 198,892	\$ 25,792	\$ 25,792	\$	5-10 YRS	\$ 124,166	71
72	Current Year Purchases	6,259	1,733	1,733		3-5 YRS	1,733	72
73	Fully Depreciated Assets	507,142					507,142	73
74								74
75	TOTALS	\$ 712,293	\$ 27,525	\$ 27,525	\$		\$ 633,041	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT / STAFF TRANS	93 FORD CLUB WAGON	1993	\$ 17,333	\$	\$	\$	7	\$ 17,333	76
77										77
78										78
79										79
80	TOTALS			\$ 17,333	\$	\$	\$		\$ 17,333	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,134,890	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,621	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,621	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)	\$ 2,436,055	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.

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

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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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: _____ *

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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	THIS SCHEDULE IS N / A								13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number Jennings Terrace, Inc.# 0010371Report Period Beginning: 07/01/05

Ending:

06/30/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/06

(last day of reporting year)

This report must be completed even if financial statements are attached

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 257,334	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable Patients (less allowance)	37,415		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,844		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)	\$ 333,593	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	574,906		13
14	Buildings, at Historical Cos	2,830,358		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cos	729,626		16
17	Accumulated Depreciation (book methods)	(2,436,055)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Cost:			19
	Accumulated Amortization			
20	Organization & Pre-Operating Cost:			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)	\$ 1,698,835	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,032,428	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 167,571	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposit			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,096		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Tax			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 240,667	\$	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)	\$ 240,667	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,791,761	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,032,428	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,043,248	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,043,248	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(251,487)	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 Purpose:		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)	\$ (251,487)	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)	\$ 1,791,761	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Jennings Terrace, Inc.

0010371

Report Period Beginning: 07/01/05

Ending: 06/30/06

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.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,551,086	1
2	Discounts and Allowances for all Levels	(3,480)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,547,606	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	2,267	13
14	Non-Patient Meals	3,185	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	775	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 6,227	23
	D. Non-Operating Revenue		
24	Contributions	11,207	24
25	Interest and Other Investment Income***	7,743	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,950	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER REVENUE	15,897	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,897	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,588,680	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	845,995	31
32	Health Care	1,226,780	32
33	General Administration	645,921	33
	B. Capital Expense		
34	Ownership	88,621	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)*	\$ 2,840,167	40
41	Income before Income Taxes (line 30 minus line 40)**	(251,487)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (251,487)	43

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

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

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

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

Facility Name & ID Number Jennings Terrace, Inc.

0010371

Report Period Beginning: 07/01/05

Ending:

06/30/06

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,000	2,080	\$ 48,146	\$ 23.15	1
2	Assistant Director of Nursing	272	320	6,873	21.48	2
3	Registered Nurses	6,720	7,260	151,539	20.87	3
4	Licensed Practical Nurses	7,930	8,449	160,283	18.97	4
5	CNAs & Orderlies	50,072	51,987	520,673	10.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,051	2,145	20,580	9.59	8
9	Activity Director	3,739	4,050	53,048	13.10	9
10	Activity Assistants	5,766	6,254	53,727	8.59	10
11	Social Service Workers	1,907	2,095	36,450	17.40	11
12	Dietician					12
13	Food Service Supervisor	2,021	2,253	36,276	16.10	13
14	Head Cook	2,067	2,196	25,487	11.61	14
15	Cook Helpers/Assistants	22,511	23,803	176,128	7.40	15
16	Dishwashers					16
17	Maintenance Workers	6,681	7,031	72,314	10.29	17
18	Housekeepers	7,970	8,452	59,747	7.07	18
19	Laundry	1,994	2,065	14,284	6.92	19
20	Administrator	2,000	2,080	75,487	36.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,389	3,572	59,956	16.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,059	2,203	21,743	9.87	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,149	138,295	\$ 1,592,741 *	\$ 11.52	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	106	\$ 3,710	Ln 1, Col 3	35
36	Medical Director	per visit	220	Ln 9, Col 3	36
37	Medical Records Consultant	13	775	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per record	585	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	per visit	2,760	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	119	\$ 8,050		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$	50	
51	Licensed Practical Nurses	695	22,935	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	1,389	26,387	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	2,084	\$ 49,322		53

Facility Name & ID Number Jennings Terrace, Inc.

0010371

Report Period Beginning: 07/01/05

Ending: 06/30/06

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
DAVID SCARPETTA	EXEC DIR	N/A	\$ 75,487	Workers' Compensation Insurance	\$ 44,754	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	43,444	Advertising: Employee Recruitment	19,418	
				FICA Taxes	117,291	Health Care Worker Background Check	150	
				Employee Health Insurance	108,283	(Indicate # of checks performed _____)		
				Employee Meals	17,800	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		DUES & SUBSCRIPTIONS	4,756	
				TUITION REIMBURSEMENT	1,405	ADVERTISING / PUBLIC RELATIONS	32,103	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 75,487					
B. Administrative - Other								
Description			Amount					
NONE			\$			Less: Public Relations Expense	(2,024)	
						Non-allowable advertising	(20,235)	
						Yellow page advertising	(2,975)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 332,977	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 32,188	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
MURPHY & MURPHY PC	LEGAL SERVICES		\$ 10,783	NONE			Out-of-State Travel	\$
SIKICH GARDNER & CO	AUDIT		8,307					
JMS ENTERPRISES	ACCOUNTING		2,235				In-State Travel	
							Seminar Expense	3,032
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 21,325	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	\$ 3,032

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Jennings Terrace, Inc.

0010371

Report Period Beginning:

07/01/05

Ending:

06/30/06

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? If YES, give association name and amount NO
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchase? What was the average life used for new equipment added during this period? YES
7 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. NOT AVAIL Line 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? If YES, give effective date of lease NO
- (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 to Schedule VII)? YES _____ NO XX If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. 32,850
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule 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 benefit on Schedule V. \$ 17,800 Has any meal income been offset against related costs? YES Indicate the amount. \$ 3,185
- (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 program during this reporting period. _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: SIKICH GARDNER & CO The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain REPORT NOT YET FINALIZED
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees _____

JENNINGS TERRACE, INC COST REPORT FOR 6/30/06
 ID: 0010371
 SUPPLEMENTAL INFORMATION

OTHER REVENUE DETAIL - PAGE 19, LINE 28

FUNDRAISING EVENTS	1,132
PAY PHONE	217
OTHER MISC INCOME	2,531
AUDIT ADJUST - PY CORRECTION	12,017
TOTAL	<u>15,897</u>

RECLASSES - PAGE 3

PAYROLL TAXES RECLASSIFIED:	
FROM COL 3, LINE ----->	
1	(17,527)
3	(4,401)
4	(1,051)
6	(5,321)
10	(66,885)
11	(7,845)
12	(2,690)
21	(11,571)
TO COL 3, LINE ----->	22 117,291

COST OF EMPLOYEE MEALS RECLASSIFIED:	
FROM COL 2, LINE ----->	2 (17,800)
TO COL 3, LINE ----->	22 17,800

NURSE AIDE TRAINING - PAGE 15

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

SEMINAR EXPENSES - PAGE 21

ATTENDEES	DATE	LOCATION	SEMINAR TITLE	SPONSOR	COST
EXEC DIR, DON, ACTIVITIES DIR, SOC SERV DIR	MAR 06	ILLINOIS	ACTIVITY SURVEY GUIDANCE & PSYCHOLOGICAL OUTCOMES EXPECT.	LSN FOUNDATION	396.00
EXEC DIR	AUG 05	ILLINOIS	MEDICARE PART D	IHCA	175.00
EXEC DIR, DON ASST DON, CNA COORD	JAN 06	ILLINOIS	MEDICAID - NEW RULES - NEW TOOLS	IHCA	380.00
EXEC DIR, DON, CAN COORD	MAR 06	ILLINOIS	MEDICARE - BACK TO BASICS	IHCA	525.00
EXEC DIR	AUG 05	ILLINOIS	PERSONAL LEADERSHIP	LSN FOUNDATION	195.00
DON, ASST DON, CNA COORD	NOV 05	ILLINOIS	MOVING FROM ASSESSMENT TO CARE	LSN FOUNDATION	285.00
DON	JUN 06	ILLINOIS	MDS	SKILLPATH	199.00
ACTIVITY AIDE	MAY 06	ILLINOIS	ACTIVITY COURSE	TRITON COLLEGE	380.00
VARIOUS	VARIOUS		OTHER MISC SEMINARS AND RELATED EXPENSE	VARIOUS	497.00
					3,032.00