

Facility Name & ID Number Jennings Terrace

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

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	<u>8</u>	Skilled (SNF)	<u>8</u>	<u>2,920</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>52</u>	Intermediate (ICF)	<u>52</u>	<u>18,980</u>	3
4		Intermediate/DD			4
5	<u>103</u>	Sheltered Care (SC)	<u>103</u>	<u>37,595</u>	5
6		ICF/DD 16 or Less			6
7	<u>163</u>	TOTALS	<u>163</u>	<u>59,495</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Medicaid Recipient	4 Private Pay	Other		
8	SNF		<u>173</u>		<u>173</u>	8
9	SNF/PED					9
10	ICF		<u>17,705</u>		<u>17,705</u>	10
11	ICF/DD					11
12	SC		<u>15,781</u>		<u>15,781</u>	12
13	DD 16 OR LESS					13
14	TOTALS		<u>33,659</u>		<u>33,659</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.57%

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.

Facility Name & ID Number

Jennings Terrace

0010371

Report Period Beginning:

07/01/06

Ending:

06/30/07

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	209,420	11,800	3,457	224,677		224,677		224,677		1
2	Food Purchase		211,932		211,932	(18,300)	193,632	(2,971)	190,661		2
3	Housekeeping	25,966	23,185	39,431	88,582		88,582		88,582		3
4	Laundry	18,154	5,532	6,862	30,548		30,548		30,548		4
5	Heat and Other Utilities			137,372	137,372		137,372		137,372		5
6	Maintenance	60,014		61,025	121,039		121,039		121,039		6
7	Other (specify):*										7
8	TOTAL General Services	313,554	252,449	248,147	814,150	(18,300)	795,850	(2,971)	792,879		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	995,836	35,179	31,533	1,062,548		1,062,548		1,062,548		10
10a	Therapy										10a
11	Activities	91,380	1,924		93,304		93,304		93,304		11
12	Social Services	33,077		1,320	34,397		34,397		34,397		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,120,293	37,103	32,853	1,190,249		1,190,249		1,190,249		16
	C. General Administration										
17	Administrative	65,736			65,736		65,736		65,736		17
18	Directors Fees										18
19	Professional Services			18,162	18,162		18,162		18,162		19
20	Dues, Fees, Subscriptions & Promotions			26,367	26,367		26,367	(11,457)	14,910		20
21	Clerical & General Office Expenses	32,579	6,645	25,386	64,610		64,610		64,610		21
22	Employee Benefits & Payroll Taxes			292,946	292,946	18,300	311,246		311,246		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,458	2,458		2,458		2,458		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			110,168	110,168		110,168		110,168		26
27	Other (specify):*										27
28	TOTAL General Administration	98,315	6,645	475,487	580,447	18,300	598,747	(11,457)	587,290		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,532,162	296,197	756,487	2,584,846		2,584,846	(14,428)	2,570,418		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:

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Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			91,110	91,110		91,110		91,110			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			91,110	91,110		91,110		91,110			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			32,850	32,850		32,850		32,850			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,532,162	296,197	880,447	2,708,806		2,708,806	(14,428)	2,694,378			45

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

Jennings Terrace

ID# 0010371

Report Period Beginning: 07/01/06

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Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	\$		1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jennings Terrace# 0010371

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	(2,971)	0	0	0	0	0	0	0	0	0	0	(2,971)	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	(2,971)	0	0	0	0	0	0	0	0	0	0	(2,971)	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	(11,457)	0	0	0	0	0	0	0	0	0	0	(11,457)	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	(11,457)	0	0	0	0	0	0	0	0	0	0	(11,457)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,428)	0	0	0	0	0	0	0	0	0	0	(14,428)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

07/01/06 Ending:

06/30/07

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(14,428)	0	0	0	0	0	0	0	0	0	0	(14,428)	45

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning: 07/01/06

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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 Organization	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

#

0010371

Report Period Beginning:

07/01/06

Ending:

06/30/07

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 SCHEDULE IS N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Jennings Terrace

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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 worksheets.

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

0010371

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

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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

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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 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 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	<u>NURSING HOME</u>	<u>475,904</u>	<u>VARIOUS</u>	<u>\$ 574,906</u>	1
2					2
3	TOTALS	475,904		\$ 574,906	3

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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	
	Bed* 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		1,009,197	5
6										6
7										7
8										8
	Improvement Type**									
9	BUILDING IMPROVEMENT		1967	34,983	437	40	437		34,983	9
10	BUILDING IMPROVEMENT		1968	8,760	219	40	219		8,650	10
11	BUILDING IMPROVEMENT		1990	4,376	109	40	109		1,883	11
12	BUILDING IMPROVEMENT		1992	4,550	163	VAR	163		4,550	12
13	BUILDING IMPROVEMENT		1993	7,238	438	15	438		6,350	13
14	BUILDING IMPROVEMENT		1994	4,677	148	VAR	148		4,530	14
15	BUILDING IMPROVEMENT - ROOF REPAIR		1996	92,951		VAR			92,951	15
16	BUILDING IMPROVEMENT		1996	5,238	473	VAR	473		5,238	16
17	BUILDING IMPROVEMENT		1998	3,243	324	10	324		2,972	17
18	BUILDING IMPROVEMENT - RETAINING WALL		1999	8,049	201	40	201		1,643	18
19	BUILDING IMPROVEMENT - RETAINING WALL		2000	8,361	209	40	209		1,498	19
20	BUILDING IMPROVEMENT - HANDICAPPED ENTRY		2000	43,900	1,098	40	1,098		8,049	20
21	BUILDING IMPROVEMENT - RETAINING WALL		2001	8,361	209	40	209		1,463	21
22	BUILDING IMPROVEMENT - WINDOWS		2001	2,666	267	10	267		1,734	22
23	BUILDING IMPROVEMENT - KITCHEN FLOOR / WINDOWS		2002	14,456	1,205	VAR	1,205		5,123	23
24	BUILDING IMPROVEMENT - KITCHEN RENOVATION / DOOR		2003	7,541	932	VAR	932		2,807	24
25	BUILDING IMPROVEMENT - MAIN BREAKER		2005	8,900	890	10	890		1,634	25
26	BUILDING IMPROVEMENT - DOOR / HVAC IMPROVEMENTS		2005	4,150	415	10	415		1,265	26
27	BUILDING IMPROVEMENT - WATER PIPE / CARPETING		2006	7,157	1,029	VAR	1,029		2,058	27
28	BUILDING IMPROVEMENT - ROOF, WIRING, FLOORING		2007	24,900	2,490	10	2,490		2,490	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.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

07/01/06

Ending:

06/30/07

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	5,160	40
41	LAND IMP - PARKING LOT	2003	30,959	3,095	10	3,095	12,976	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	388	50
51	LAND IMP - SIDEWALK	1998	1,592	159	10	159	1,552	51
52	LAND IMP - SIDEWALK	2002	225	11	20	11	62	52
53	LAND IMP - FENCE	2003	3,581	358	10	358	1,667	53
54	LAND IMP - FENCE	2004	4,353	290	15	290	1,086	54
55	LAND IMP - TREE REMOVAL / CONCRETE	2005	15,812	1,054	15	1,054	2,153	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)		\$ 2,855,258	\$ 63,586		\$ 63,586	\$ 1,849,267	70

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

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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	\$ 205,151	\$ 27,524	\$ 27,524	\$	3-10 YRS	\$ 153,423	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	507,142					507,142	73
74								74
75	TOTALS	\$ 712,293	\$ 27,524	\$ 27,524	\$		\$ 660,565	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)	\$ 4,159,790	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 91,110	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 91,110	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)	\$ 2,527,165	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.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: THIS SCHEDULE IS N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			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.

STATE OF ILLINOIS

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Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning: 07/01/06

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06/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/07

(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	\$ 409,125	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	112,393		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,471		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)	\$ 536,989	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	574,906		13
14	Buildings, at Historical Cost	2,855,258		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	729,626		16
17	Accumulated Depreciation (book methods)	(2,527,165)		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)	\$ 1,632,625	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,169,614	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 53,873	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	84,079		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEFERRED REVENUE	118,995		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 256,947	\$	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)	\$ 256,947	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,912,667	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,169,614	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,791,763	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,791,763	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	120,904	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)	\$ 120,904	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)	\$ 1,912,667	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.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,945,145	1
2	Discounts and Allowances for all Levels	(153,954)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,791,191	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	2,580	13
14	Non-Patient Meals	2,971	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	370	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 5,921	23
D. Non-Operating Revenue			
24	Contributions	11,100	24
25	Interest and Other Investment Income***	9,560	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20,660	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER REVENUE	11,938	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,938	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,829,710	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	814,150	31
32	Health Care	1,190,249	32
33	General Administration	580,447	33
B. Capital Expense			
34	Ownership	91,110	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)*	\$ 2,708,806	40
41	Income before Income Taxes (line 30 minus line 40)**	120,904	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 120,904	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.

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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	2,080	2,080	\$ 52,000	\$ 25.00	1
2	Assistant Director of Nursing	1,978	2,254	47,069	20.88	2
3	Registered Nurses	4,932	5,863	102,017	17.40	3
4	Licensed Practical Nurses	10,188	12,803	233,847	18.27	4
5	CNAs & Orderlies	44,950	49,020	460,914	9.40	5
6	CNA Trainees	7,713	9,508	59,522	6.26	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,051	2,145	20,580	9.59	8
9	Activity Director	3,775	4,122	51,070	12.39	9
10	Activity Assistants	4,521	4,950	40,310	8.14	10
11	Social Service Workers	1,805	2,005	33,077	16.50	11
12	Dietician					12
13	Food Service Supervisor	1,770	2,017	30,155	14.95	13
14	Head Cook	1,937	2,166	24,401	11.27	14
15	Cook Helpers/Assistants	21,188	22,374	154,864	6.92	15
16	Dishwashers					16
17	Maintenance Workers	4,310	4,467	60,014	13.43	17
18	Housekeepers	3,355	3,594	25,966	7.22	18
19	Laundry	2,201	2,273	18,154	7.99	19
20	Administrator	2,000	2,080	65,736	31.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,914	2,114	32,579	15.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,955	2,135	19,887	9.31	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,623	137,970	\$ 1,532,162 *	\$ 11.11	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	99	\$ 3,457	Ln 1, Col 3	35
36	Medical Director	per visit	0	Ln 9, Col 3	36
37	Medical Records Consultant	16	990	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per record	386	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	1,320	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	115	\$ 6,153		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	140	\$ 5,056	Ln 10, Col 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,168	25,101	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	1,308	\$ 30,157		53

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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	\$ 65,736	Workers' Compensation Insurance	\$ 57,257	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	28,308	Advertising: Employee Recruitment	8,328	
				FICA Taxes	113,424	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	85,837	Patient Background Checks		
				Employee Meals	18,300	DUES & SUBSCRIPTIONS	4,592	
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING / PUBLIC RELATIONS	11,457	
				TUITION REIMBURSEMENT	2,540			
				EMPLOYEE INCENTIVES	5,580			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 65,736	TOTAL (agree to Schedule V, line 22, col.8)		\$ 311,246		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
NONE			\$	NONE			Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	In-State Travel	
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type	Amount					2,458	
JAMES R MURPHY	LEGAL	\$ 72					Entertainment Expense (agree to Sch. V, line 24, col. 8)	
SIKICH GARDNER LLP	AUDIT	7,700					TOTAL	
JMS ENTERPRISES	ACCOUNTING	10,390					\$ 2,458	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 18,162					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning: 07/01/06

Ending: 06/30/07

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (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? NONE
- (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? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES XX NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO XX If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,850
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 18,300 Has any meal income been offset against related costs? YES Indicate the amount. \$ 2,971
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm WILL BE
Firm Name: SIKICH GARDNER LLP 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. AUDIT NOT COMPLETED YET
- (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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

JENNINGS TERRACE, INC

COST REPORT FOR 6/30/07

ID: 0010371

SUPPLEMENTAL INFORMATION

OTHER REVENUE DETAIL - PAGE 19, LINE 28

FUNDRAISING EVENTS	1,108
PAY PHONE	54
OTHER MISC INCOME	4,832
PRIOR YR WORKERS COMP REFUND	5,944
TOTAL	<u>11,938</u>

RECLASSES - PAGE 3

COST OF EMPLOYEE MEALS RECLASSED:

FROM COL 2, LINE ----->	2	(18,300)
TO COL 3, LINE ----->	22	18,300

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
FOOD SERV DIR	APR 07	ILLINOIS	STATE DIETARY MEETING	DIETARY MGRS ASSOCIATION	60.00
EXEC DIR, DON ASST DON, CNA COORD	MAR 07	ILLINOIS	ANNUAL CONVENTION	LSN FOUNDATION	1,995.00
VARIOUS	VARIOUS		OTHER MISC SEMINARS AND RELATED EXPENSE	VARIOUS	403.00
					2,458.00