



Facility Name & ID Number JENNINGS TERRACE

# 0010371 Report Period Beginning: 7/1/2013 Ending: 6/30/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 09/08

	1	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	2,760			2,760	8
9	SNF/PED					9
10	ICF		14,813		14,813	10
11	ICF/DD					11
12	SC		24,525		24,525	12
13	DD 16 OR LESS					13
14	TOTALS	2,760	39,338		42,098	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.76%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

NO

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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 03/16/43

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.

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
	<b>A. General Services</b>										
1	Dietary	293,324	3,751	5,616	302,691		302,691		302,691		1
2	Food Purchase		314,385		314,385	(33,670)	280,715	(18,724)	261,991		2
3	Housekeeping	45,571	22,731	26,713	95,015		95,015		95,015		3
4	Laundry	24,497	8,261	4,455	37,213		37,213		37,213		4
5	Heat and Other Utilities			142,395	142,395		142,395		142,395		5
6	Maintenance	80,887	15,410	55,688	151,985		151,985		151,985		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	444,279	364,538	234,867	1,043,684	(33,670)	1,010,014	(18,724)	991,290		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,351,326	57,549	27,084	1,435,959		1,435,959		1,435,959		10
10a	Therapy										10a
11	Activities	124,469	2,135		126,604		126,604		126,604		11
12	Social Services	42,835	101	6,630	49,566		49,566		49,566		12
13	CNA Training										13
14	Program Transportation			4,797	4,797		4,797	(1,307)	3,490		14
15	Other (specify):*			97,944	97,944		97,944		97,944		15
16	<b>TOTAL Health Care and Programs</b>	1,518,630	59,785	136,455	1,714,870		1,714,870	(1,307)	1,713,563		16
	<b>C. General Administration</b>										
17	Administrative	81,741			81,741		81,741		81,741		17
18	Directors Fees										18
19	Professional Services			39,353	39,353		39,353		39,353		19
20	Dues, Fees, Subscriptions & Promotions			39,236	39,236		39,236	(32,340)	6,896		20
21	Clerical & General Office Expenses	80,157	2,506	49,911	132,574		132,574		132,574		21
22	Employee Benefits & Payroll Taxes			437,351	437,351	33,670	471,021		471,021		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,227	2,227		2,227		2,227		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			74,267	74,267		74,267		74,267		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	161,898	2,506	642,345	806,749	33,670	840,419	(32,340)	808,079		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,124,807	426,829	1,013,667	3,565,303		3,565,303	(52,371)	3,512,932		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number JENNINGS TERRACE

#0010371

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

## 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	
	<b>D. Ownership</b>											
30	Depreciation			117,667	117,667		117,667		117,667			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	<b>TOTAL Ownership</b>			117,667	117,667		117,667		117,667			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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	<b>TOTAL Special Cost Centers</b>			32,850	32,850		32,850		32,850			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,124,807	426,829	1,164,184	3,715,820		3,715,820	(52,371)	3,663,449			45

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

Facility Name & ID Number JENNINGS TERRACE

# 0010371

Report Period Beginning: 7/1/2013

Ending: 6/30/2014

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer-</b>	<b>BHF USE</b>	
			<b>ence</b>	<b>ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,724)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,307)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,376)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(13,964)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (52,371)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (52,371)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>						
48		49		50		51
						52

JENNINGS TERRACE

ID# 0010371

Report Period Beginning: 7/1/2013

Ending: 6/30/2014

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	<b>Total</b>		0	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number JENNINGS TERRACE# 0010371

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(18,724)	0	0	0	0	0	0	0	0	0	0	(18,724)	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	<b>TOTAL General Services</b>	<b>(18,724)</b>	<b>0</b>	<b>(18,724)</b>	<b>8</b>									
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,307)	0	0	0	0	0	0	0	0	0	0	(1,307)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,307)</b>	<b>0</b>	<b>(1,307)</b>	<b>16</b>									
	<b>C. General Administration</b>													
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	(32,340)	0	0	0	0	0	0	0	0	0	0	(32,340)	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	<b>TOTAL General Administration</b>	<b>(32,340)</b>	<b>0</b>	<b>(32,340)</b>	<b>28</b>									
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(52,371)</b>	<b>0</b>	<b>(52,371)</b>	<b>29</b>									

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number JENNINGS TERRACE# 0010371

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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

	Capital Expense	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)	
	<b>D. Ownership</b>													
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	<b>TOTAL Ownership</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(52,371)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(52,371)</b>	<b>45</b>

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE SUPP FOR BOARD OF DIRECTORS LISTING						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

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

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

Facility Name & ID Number

JENNINGS TERRACE

# 0010371

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	LYNN AKERS	BOD						2
3	JACK SMITH	BOD						3
4	ATTY JAMES CHEATHAM	BOD						4
5	DOUGLAS CHEATHAM	BOD						5
6	MICHAEL MARZEC MD	BOD						6
7	MOLLIE MILLEN	BOD						7
8	TIM McCANN	BOD						8
9	JOSEPH JACOBS	BOD						9
10	JESS TOUSSAINT	BOD						10
11	JONATHAN BIERITZ	BOD						11
12	MARIAN MOORE	BOD						12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

JENNINGS TERRACE

#

0010371

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

## 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

# 0010371 Report Period Beginning: 7/1/2013

Ending: 7/30/2014

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

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

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

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.)

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2013 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 2014 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$			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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$			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:	2009 _____	8	<b>FOR BHF USE ONLY</b>			
	2010 _____	9				
	2011 _____	10				
	2012 _____	11				
	2013 _____	12				
<b>THIS SCHEDULE IS N/A</b>			13	FROM R. E. TAX STATEMENT FOR 2013	\$	13
			14	PLUS APPEAL COST FROM LINE 5	\$	14
			15	LESS REFUND FROM LINE 6	\$	15
			16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2013 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 2013 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 2013.

	(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.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>_____</u>	\$ <u>_____</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES                 NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number JENNINGS TERRACE

# 0010371 Report Period Beginning:

7/1/2013 Ending:

6/30/2014

**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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>NURSING HOME</u>	<u>475,304</u>	<u>VARIOUS</u>	<u>\$ 574,906</u>	1
2					2
3	<b>TOTALS</b>	<b>475,304</b>		<b>\$ 574,906</b>	3

Facility Name &amp; ID Number JENNINGS TERRACE

# 0010371

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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		1,335,243	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	BUILDING IMPROVEMENT	1967		34,983		40			34,983	9
10	BUILDING IMPROVEMENT	1968		8,760		40			8,760	10
11	BUILDING IMPROVEMENT	1990		4,376	109	40	109		2,646	11
12	BUILDING IMPROVEMENT	1992		4,550		VAR			4,550	12
13	BUILDING IMPROVEMENT	1993		7,238		15			7,238	13
14	BUILDING IMPROVEMENT	1994		4,677		VAR			4,677	14
15	BUILDING IMPROVEMENT - ROOF REPAIR	1996		92,951		VAR			92,951	15
16	BUILDING IMPROVEMENT	1996		5,238		VAR			5,238	16
17	BUILDING IMPROVEMENT	1998		3,243		10			3,243	17
18	BUILDING IMPROVEMENT - RETAINING WALL	1999		8,049	322	40	322		3,897	18
19	BUILDING IMPROVEMENT - RETAINING WALL	2000		8,361	334	40	334		3,836	19
20	BUILDING IMPROVEMENT - HANDICAPPED ENTRY	2000		43,900	1,756	40	1,756		20,341	20
21	BUILDING IMPROVEMENT - RETAINING WALL	2001		8,361	334	40	334		3,801	21
22	BUILDING IMPROVEMENT - WINDOWS	2001		2,666		10			2,666	22
23	BUILDING IMPROVEMENT - KITCHEN FLOOR / WINDOWS	2002		14,456	994	VAR	994		12,964	23
24	BUILDING IMPROVEMENT - KITCHEN RENOVATION / DOOR	2003		7,541	210	VAR	210		7,541	24
25	BUILDING IMPROVEMENT - MAIN BREAKER	2005		8,900	890	10	890		7,864	25
26	BUILDING IMPROVEMENT - DOOR / HVAC IMPROVEMENTS	2005		4,150	395	10	395		4,150	26
27	BUILDING IMPROVEMENT - WATER PIPE / CARPETING	2006		7,157	403	VAR	403		6,758	27
28	BUILDING IMPROVEMENT - ROOF, WIRING, FLOORING	2007		24,900	2,490	10	2,490		19,920	28
29	BUILDING IMPROVEMENT - LOCKER ROOM REMODEL	2008		7,500	750	10	750		4,875	29
30	BUILDING IMPROVEMENT - BATHROOM REMODEL	2008		44,531	2,969	15	2,969		19,298	30
31	BUILDING IMPROVEMENT - ROOF REPAIR	2008		7,909	791	10	791		5,142	31
32	BUILDING IMPROVEMENT - ROOF REPAIR	2009		15,332	1,533	10	1,533		9,198	32
33	BUILDING IMPROVEMENT - CARPETING	2010		9,033	1,807	5	1,807		8,132	33
34	BUILDING IMPROVEMENT - ROOF REPAIR	2011		12,943	1,294	10	1,294		4,529	34
35	BUILDING IMPROVEMENT - REMODEL SHOWERS	2011		26,801	1,787	15	1,787		6,255	35
36	BUILDING IMPROVEMENT - WALL HEATER, RAILINGS	2011		9,095	1,102	VAR	1,102		3,857	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 &amp; ID Number JENNINGS TERRACE

# 0010371

Report Period Beginning:

7/1/2013

Ending:

6/30/2014

## XI. OWNERSHIP COSTS (continued)

## B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	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	BUILDING IMPROVEMENT - SHOWER REMODEL	2012	\$ 7,900	\$ 790	10	\$ 790	\$	\$ 1,975	37
38	BUILDING IMPROVEMENT - CARPETING	2012	5,525	1,105	5	1,105		2,763	38
39	BUILDING IMPROVEMENT - NEW ROOF	2012	80,440	5,363	15	5,363		13,406	39
40	BUILDING IMPROVEMENT - EMERGENCY CIRCUITS	2012	4,985	712	7	712		2,136	40
41	BUILDING IMPROVEMENT - MULTIPURPOSE RM WINDOWS	2013	4,000	400	10	400		600	41
42	BUILDING IMPROVEMENT - NEW FLOORING ANNEX	2014	41,170	2,058	10	2,058		2,058	42
43									43
44	LAND IMP - PARKING LOT	1974	470		7			470	44
45	LAND IMP - PARKING LOT	1985	880		7			880	45
46	LAND IMP - PARKING LOT	1992	7,445		10			7,445	46
47	LAND IMP - PARKING LOT - BLACKTOP	2001	7,549		10			7,549	47
48	LAND IMP - PARKING LOT - FRONT ENTRANCE	2003	30,959		10			30,959	48
49	LAND IMP - PARKING LOT - LIGHTS	2010	3,518	352	10	352		1,584	49
50	LAND IMP - PARKING LOT - RESURFACE	2013	6,389	639	10	639		958	50
51									51
52	LAND IMP - VARIOUS	1978	2,317		10			2,317	52
53	LAND IMP - VARIOUS	1982	1,007		10			1,007	53
54	LAND IMP - VARIOUS	1988	4,084		10			4,084	54
55	LAND IMP - YARD LIGHTS	1989	1,390		15			1,390	55
56	LAND IMP - SIDEWALK	1990	1,450		10			1,450	56
57	LAND IMP - SIDEWALK	1991	600		10			600	57
58	LAND IMP - SIDEWALK	1994	440		15			440	58
59	LAND IMP - SIDEWALK	1998	1,592		10			1,592	59
60	LAND IMP - SIDEWALK	2002	225	31	10	31		225	60
61	LAND IMP - FENCE	2003	3,581		10			3,581	61
62	LAND IMP - FENCE	2004	4,353	435	10	435		4,133	62
63	LAND IMP - TREE REMOVAL / CONCRETE	2005	15,812	1,581	10	1,581		13,220	63
64	LAND IMP - TERRACE	2010	35,935	2,396	15	2,396		10,782	64
65	LAND IMP - CONCRETE WORK	2011	3,332	333	10	333		1,332	65
66	LAND IMP - EASTSIDE ENTRY	2014	6,400	640	10	640		640	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,187,996	\$ 83,683		\$ 83,683	\$	\$ 2,377,641	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 168,871	\$ 26,296	\$ 26,296	\$		\$ 117,780	71
72	Current Year Purchases	27,480	2,838	2,838			2,838	72
73	Fully Depreciated Assets	709,854					709,854	73
74								74
75	<b>TOTALS</b>	\$ 906,205	\$ 29,134	\$ 29,134	\$		\$ 830,472	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT / STAFF TRANS	93 FORD CLUB WAGON	1993	\$ 17,333	\$	\$	\$		\$ 17,333	76
77	RESIDENT / STAFF TRANS	08 STARCRAFT VAN	2009	48,491	4,850	4,850		5	48,491	77
78										78
79										79
80	<b>TOTALS</b>			\$ 65,824	\$ 4,850	\$ 4,850	\$		\$ 65,824	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)	\$ 4,734,931	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,667	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,667	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,273,937	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	<b>TOTALS</b>	\$	\$	\$	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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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.

Facility Name & ID Number JENNINGS TERRACE # 0010371 Report Period Beginning: 7/1/2013 Ending: 6/30/2014  
**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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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**

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

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

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

Facility Name & ID Number **JENNINGS TERRACE**# **0010371**Report Period Beginning: **7/1/2013**

Ending:

**6/30/2014****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2014**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,686,457	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	50,237		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,702		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,764,396	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	574,906		13
14	Buildings, at Historical Cost	3,187,996		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	972,029		16
17	Accumulated Depreciation (book methods)	(3,273,937)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,460,994	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,225,390	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 59,777	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	103,242		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
	<b>Other Current Liabilities(specify):</b>			
36	<b>DEFERRED REVENUE</b>	122,432		36
37	<b>NURSING HOME TAX</b>	49,000		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 334,451	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 334,451	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,890,939	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,225,390	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 3,017,889	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 3,017,889	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(126,950)	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (126,950)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>		23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 2,890,939	24 *

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

Facility Name &amp; ID Number JENNINGS TERRACE

# 0010371

Report Period Beginning: 7/1/2013

Ending:

6/30/2014

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	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,568,418	1
2	Discounts and Allowances for all Levels	(45,878)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,522,540	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	2,281	13
14	Non-Patient Meals	18,724	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 21,005	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	37,552	24
25	Interest and Other Investment Income***	4,252	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 41,804	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>OTHER INCOME</b>	3,521	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,521	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,588,870	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,043,684	31
32	Health Care	1,714,870	32
33	General Administration	806,749	33
<b>B. Capital Expense</b>			
34	Ownership	117,667	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	32,850	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,715,820	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(126,950)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (126,950)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 261,077	44
45	Private Pay - Net Inpatient Revenue	3,261,463	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,522,540	49

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

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

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

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

Facility Name & ID Number **JENNINGS TERRACE**

# **0010371**

Report Period Beginning: **7/1/2013**

Ending:

**6/30/2014**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,912	2,080	\$ 57,920	\$ 27.85	1
2	Assistant Director of Nursing	2,266	2,377	50,865	21.40	2
3	Registered Nurses	6,441	6,605	146,373	22.16	3
4	Licensed Practical Nurses	10,943	11,386	251,036	22.05	4
5	CNAs & Orderlies	48,006	49,521	609,673	12.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,868	2,051	22,210	10.83	8
9	Activity Director	2,043	2,159	39,924	18.49	9
10	Activity Assistants	8,077	8,428	84,545	10.03	10
11	Social Service Workers	1,735	1,915	42,835	22.37	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,100	43,690	20.80	13
14	Head Cook	4,194	4,562	66,382	14.55	14
15	Cook Helpers/Assistants	20,684	21,206	183,252	8.64	15
16	Dishwashers					16
17	Maintenance Workers	5,117	5,288	80,887	15.30	17
18	Housekeepers	4,860	5,046	45,571	9.03	18
19	Laundry	2,832	2,887	24,497	8.49	19
20	Administrator	1,912	2,080	81,741	39.30	20
21	Assistant Administrator					21
22	Other Administrative	3,222	3,456	80,157	23.19	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,941	2,081	23,180	11.14	31
32	Other Health C: <b>NURSE AIDES</b>	23,158	23,517	190,069	8.08	32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>153,155</b>	<b>158,745</b>	<b>\$ 2,124,807 *</b>	<b>\$ 13.39</b>	<b>34</b>

\* 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	135	\$ 5,616	Ln 1, Col 3	35
36	Medical Director				36
37	Medical Records Consultant	13	780	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per record	2,703	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	6,630	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>148</b>	<b>\$ 15,729</b>		<b>49</b>

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	171	\$ 7,363	Ln 10, Col 3	50
51	Licensed Practical Nurses	93	3,779	Ln 10, Col 3	51
52	Certified Nurse Assistants/Aides	182	3,810	Ln 10, Col 3	52
53	<b>TOTAL (lines 50 - 52)</b>	<b>446</b>	<b>\$ 14,952</b>		<b>53</b>

Facility Name & ID Number JENNINGS TERRACE

Report Period Beginning: 7/1/2013

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	NONE	\$ 81,741	Workers' Compensation Insurance	\$ 46,110	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	57,819	Advertising: Employee Recruitment	1,616	
				FICA Taxes	158,392	Health Care Worker Background Check		
				Employee Health Insurance	164,928	(Indicate # of checks performed 34 )	550	
				Employee Meals	33,670	Patient Background Checks 47	750	
				Illinois Municipal Retirement Fund (IMRF)*		ADVERTISING	32,340	
				EMPLOYEE INCENTIVES	7,600			
				OTHER	2,502			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,741	TOTAL (agree to Schedule V, line 22, col.8)		\$ 471,021		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising (18,376)	
NONE			\$				Yellow page advertising (13,964)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				TOTAL (agree to Sch. V, line 20, col. 8) \$ 6,896	
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
SIKICH GARDNER LLP	AUDIT / CONSULT		\$ 10,530	NONE		\$	Out-of-State Travel	\$
JMS ENTERPRISES	ACCOUNTING		13,815					
DREYER FOOTE ETAL	LEGAL		9,737				In-State Travel	
JEREMY BRUNE CPA	CONSULT		271					
JB ARCHITECTURE	CONSULT		5,000				Seminar Expense	2,227
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 39,353	TOTAL		\$	Entertainment Expense ( )	
							TOTAL (agree to Sch. V, line 24, col. 8) \$ 2,227	

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	<b>THIS SCHEDULE IS N/A</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number JENNINGS TERRACE

# 0010371

Report Period Beginning: 7/1/2013

Ending: 6/30/2014

## 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? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (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? 5 YEARS
- (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 \_\_\_\_\_
- (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. \$ 33,670 Has any meal income been offset against related costs? YES Indicate the amount. \$ 18,724
- (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
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES  
Attach invoices and a summary of services for all architect and appraisal fees.

JENNINGS TERRACE, INC

COST REPORT FOR 6/30/14

ID: 0010371

SUPPLEMENTAL INFORMATION

OTHER REVENUE DETAIL - PAGE 19, LINE 28

TRANSPORTATION CHARGES	1,307
MISCELLANEOUS INCOME	2,214
TOTAL	<u>3,521</u>

OTHER EXPENSES - PAGE 3, LINE 15

NURSING HOME TAX	97,944
TOTAL	<u>97,944</u>

RECLASSES - PAGE 3

COST OF EMPLOYEE MEALS RECLASSIFIED:		
FROM COL 2, LINE ----->	2	(33,670)
TO COL 3, LINE ----->	22	33,670

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
VAR EMPLOYEES	07/01/2013	ON SITE	CPR	Embrace	420.00
VARIOUS NURSING	07/16/2013	ON SITE	nursing seminar	Mary Foote	125.00
EXEC DIR	08/30/2013	SPRINGFIELD	Administrator Rules/Regs	IL Nursing Home Admistra	297.34
FOOD SERV DIR	10/17/2013	PEORIA	IANFP Workshop	IANFP	147.80
EXEC DIR	12/05/2013	OAK LAWN	Create an Environment	Illinois Council	81.00

ADMIN STAFF	01/24/2014 AURORA	Hr policies	Aurora Chamber	25.00
DON	02/04/2014 NAPERVILLE	D.O.N. in LTC	Life Services Network	650.00
NURSING STAFF	02/06/2014		PESI, Inc.	379.98
NURSING STAFF	02/21/2014 ON LINE	Institute for Natural Resou	INR	81.00
EXEC DIR	05/13/2014 AURORA	FLSA update	Aurora Chamber	20.00
				2,227.12

JENNINGS TERRACE INC

COST REPORT FOR 6/30/14

ID: 0010371

LISTING OF LEGAL FEES - INVOICES ATTACHED

07/31/2013	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	300.00
07/31/2013	15904-004M	Law Firm of Dreyer, Foote, Streit, Furg	921.12
07/31/2013	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	510.00
09/01/2013	15904-004M	Law Firm of Dreyer, Foote, Streit, Furg	1,360.72
09/01/2013	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	561.10
09/01/2013	15904-015M	Law Firm of Dreyer, Foote, Streit, Furg	50.00
10/01/2013	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	200.00
10/01/2013	15904-004M	Law Firm of Dreyer, Foote, Streit, Furg	40.00
10/01/2013	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	1,107.10
10/01/2013	15904-014M	Law Firm of Dreyer, Foote, Streit, Furg	200.00
11/01/2013	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	400.00
11/01/2013	15904-004M	Law Firm of Dreyer, Foote, Streit, Furg	40.00
11/01/2013	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	1,192.20
11/01/2013	15904-015M	Law Firm of Dreyer, Foote, Streit, Furg	160.00
11/30/2013	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	560.00
11/30/2013	15904-004M	Law Firm of Dreyer, Foote, Streit, Furg	391.10
11/30/2013	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	63.04
12/31/2013	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	50.00
12/31/2013	15904-004M	Law Firm of Dreyer, Foote, Streit, Furg	330.00
12/31/2013	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	411.10
02/01/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	100.00
02/28/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	150.00
03/31/2014	15904-000M	Law Firm of Dreyer, Foote, Streit, Furg	110.00
03/31/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	230.00
05/01/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	250.00
05/31/2014	15904-013M	Law Firm of Dreyer, Foote, Streit, Furg	50.00
			9,737.48

LISTING OF ARCHITECTUAL FEES - INVOICES ATTACHED

5,000