

		FOR BHF USE					

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0010371</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Jennings Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>7/1/2019</u> to <u>6/30/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																																	
Address: <u>275 South LaSalle</u> <u>Aurora</u> <u>60505</u>																																																			
Number City Zip Code																																																			
County: <u>Kane</u>																																																			
Telephone Number: <u>(630) 897-6947</u> Fax # <u>(630) 897-6949</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>07/05/1943</u>																																																			
Type of Ownership:																																																			
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County			☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____				
☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL																																														
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		☐	Limited Liability Co.																																																
		☐	Trust																																																
		☐	Other _____																																																
IRS Exemption Code <u>501 (c)(3)</u>																																																			
In the event there are further questions about this report, please contact:																																																			
Name: <u>David M Underwood</u>																																																			
Telephone Number: <u>(309)8237135</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Type or Print Name) <u>David M Underwood</u></td></tr><tr><td>(Title) <u>EVP & CFO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td></td><td>(Firm Name & Address) _____</td></tr><tr><td></td><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>David M Underwood</u>	(Title) <u>EVP & CFO</u>	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>																																			
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	(Telephone) <u>()</u> Fax # <u>()</u>																																																		
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																																	

Facility Name & ID Number Jennings Terrace

0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020

III. STATISTICAL DATA

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

	1	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>12</u>	Skilled (SNF)	<u>12</u>	<u>4,392</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>48</u>	Intermediate (ICF)	<u>48</u>	<u>17,568</u>	3
4		Intermediate/DD			4
5	<u>103</u>	Sheltered Care (SC)	<u>103</u>	<u>37,698</u>	5
6		ICF/DD 16 or Less			6
7	<u>163</u>	TOTALS	<u>163</u>	<u>59,658</u>	7

B. Census-For the entire report period.

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

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

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

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

F. Does the facility maintain a daily midnight census? Yes

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

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 03/16/1943

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 0

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 7/1/2019 Ending: 6/30/2020
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

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

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			120,000	120,000		120,000		120,000			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,146	1,146		1,146	(1,146)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,696	35,696		35,696		35,696			35
36	Other (specify):*											36
37	TOTAL Ownership			156,842	156,842		156,842	(1,146)	155,696			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					6,121	6,121		6,121			39
40	Barber and Beauty Shops		52	4,645	4,697		4,697		4,697			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					145,672	145,672		145,672			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		52	4,645	4,697	151,793	156,490		156,490			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,616,036	576,942	1,548,309	4,741,287		4,741,287	(10,274)	4,731,013			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,146)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(204)			17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,350)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,574)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,274)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (10,274)		37

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

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

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

Jennings Terrace

ID#	0010371
Report Period Beginning:	7/1/2019
Ending:	6/30/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11		(5,350)	19	11
12		(1,146)	32	12
13		0	27	13
14		(3,574)	20	14
15		(204)	20	15
16		0	27	16
17		0	24	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,274)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jennings Terrace# 0010371

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	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	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,350)	0	0	0	0	0	0	0	0	0	0	(5,350)	19
20	Fees, Subscriptions & Promotions	(3,778)	0	0	0	0	0	0	0	0	0	0	(3,778)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(9,128)	0	0	0	0	0	0	0	0	0	0	(9,128)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,128)	0	0	0	0	0	0	0	0	0	0	(9,128)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	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	(1,146)	0	0	0	0	0	0	0	0	0	0	(1,146)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,146)	0	0	0	0	0	0	0	0	0	0	(1,146)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,274)	0	0	0	0	0	0	0	0	0	0	(10,274)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Board of Directors List Attached						
(Not for profit Board-No individual						
ownership)						

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

YES

XX NO

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	Board Members are not compensated for their services				0	0			\$ 0		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: 7/1/2019 Ending: 5/30/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$		\$			\$		1					
2														2					
3														3					
4														4					
5														5					
	Working Capital																		
6	Old Second National Bank		xx									1,146		6					
7														7					
8														8					
9	TOTAL Facility Related						\$		\$			\$	1,146	9					
	B. Non-Facility Related*																		
10	Interest Income											(1,146)		10					
11														11					
12														12					
13														13					
14	TOTAL Non-Facility Related						\$		\$			\$	(1,146)	14					
15	TOTALS (line 9+line14)						\$		\$			\$		15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line #

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

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

FACILITY NAME Jennings Terrace COUNTY Kane
FACILITY IDPH LICENSE NUMBER 0010371
CONTACT PERSON REGARDING THIS REPORT _____
TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

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.

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

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	\$		\$		4
5	60		1985	1985	1,863,135					5
6										6
7										7
8										8
	Improvement Type**									
9	BUILDING IMPROVEMENT			1967	34,983					9
10	BUILDING IMPROVEMENT			1968	8,760					10
11	BUILDING IMPROVEMENT			1990	4,376					11
12	BUILDING IMPROVEMENT			1992	4,550					12
13	BUILDING IMPROVEMENT			1993	7,238					13
14	BUILDING IMPROVEMENT			1994	4,677					14
15	BUILDING IMPROVEMENT			1996	98,189					15
16	BUILDING IMPROVEMENT			1998	3,243					16
17	BUILDING IMPROVEMENT			1999	8,049					17
18	BUILDING IMPROVEMENT			2000	52,261					18
19	BUILDING IMPROVEMENT			2001	11,027					19
20	BUILDING IMPROVEMENT			2002	14,456					20
21	BUILDING IMPROVEMENT			2003	7,541					21
22	BUILDING IMPROVEMENT			2005	13,050					22
23	BUILDING IMPROVEMENT			2006	7,157					23
24	BUILDING IMPROVEMENT			2007	24,900					24
25	BUILDING IMPROVEMENT			2008	59,940					25
26	BUILDING IMPROVEMENT			2009	15,332					26
27	BUILDING IMPROVEMENT			2010	9,033					27
28	BUILDING IMPROVEMENT			2011	48,839					28
29	BUILDING IMPROVEMENT			2012	98,850					29
30	BUILDING IMPROVEMENT			2013	4,000					30
31	BUILDING IMPROVEMENT			2014	41,170					31
32	BUILDING IMPROVEMENT - NEW FLOORING ANNEX			2015	55,173					32
33	BUILDING IMPROVEMENT - GENERATOR			2016	38,037					33
34	BUILDING IMPROVEMENT - COOLING TOWER			2016	28,175					34
35	Book Depreciation					89,760		89,760		35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

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

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

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

7/1/2019

Ending:

6/30/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,230,582	\$ 30,240	\$ 30,240	\$		\$	71
72	Current Year Purchases	51,740						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,282,322	\$ 30,240	\$ 30,240	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,790,221	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 120,000	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 120,000	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:None
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☐ YES☒ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy:☐ YES☐ NOTerms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$35,696Description:
(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.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

COMMUNITY COLLEGE☐

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☐

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 0	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs			0				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			0	0			4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				6,121		6,121	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					0				13
14	TOTAL			\$		\$	\$ 6,121		\$ 6,121	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,451,502	\$	1
2	Cash-Patient Deposits	1,374		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(101,288)		3
4	Supply Inventory (priced at FIFO)	20,181		4
5	Short-Term Investments			5
6	Prepaid Insurance	46,770		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,418,539	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	730,043		13
14	Buildings, at Historical Cost	3,798,827		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,340,651		16
17	Accumulated Depreciation (book methods)	(3,967,657)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,901,864	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,320,403	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 197,016	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,394		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	207,369		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,417		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	10,374		36
37	Deferred Stimulus Revenue	100,000		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 526,570	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 526,570	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,793,833	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,320,403	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,146,918	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,146,918	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(353,085)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (353,085)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,793,833	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning: 7/1/2019

Ending:

6/30/2020

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,389,000	1
2	Discounts and Allowances for all Levels	(1,916)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,387,084	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,643	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,507	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,150	23
	D. Non-Operating Revenue		
24	Contributions	37,478	24
25	Interest and Other Investment Income***	66,891	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 104,369	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net realized/unrealized investment loss	(123,401)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (123,401)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,388,202	30

2

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

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

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

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

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

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	3,802	4,045	\$ 143,655	\$ 35.51	1
2	Assistant Director of Nursing	419	446	18,514	41.51	2
3	Registered Nurses	8,364	8,898	287,587	32.32	3
4	Licensed Practical Nurses	8,496	9,038	261,504	28.93	4
5	CNAs & Orderlies	47,794	50,845	780,380	15.35	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,978	2,104	41,822	19.88	8
9	Activity Director					9
10	Activity Assistants	5,430	5,777	87,486	15.14	10
11	Social Service Workers	3,268	3,477	81,172	23.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	27,791	29,565	397,853	13.46	15
16	Dishwashers					16
17	Maintenance Workers	4,410	4,691	94,924	20.24	17
18	Housekeepers	6,013	6,397	79,761	12.47	18
19	Laundry	3,264	3,472	53,551	15.42	19
20	Administrator	1,955	2,080	110,978	53.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,807	7,242	176,849	24.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	129,791	138,077	\$ 2,616,036 *	\$ 18.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 18,083	Ln 1 Col 3	35
36	Medical Director		325	Ln 18 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,874	Ln 10 Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,107	Ln 22 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 25,389		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Kristen Hendricks	Administrator	None	\$ 110,978	Workers' Compensation Insurance	\$ 58,038	IDPH License Fee	\$	
				Unemployment Compensation Insurance	40,064	Advertising: Employee Recruitment	5,052	
				FICA Taxes	200,127	Health Care Worker Background Check		
				Employee Health Insurance	154,413	(Indicate # of checks performed)	843	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*				
							3,574	
TOTAL (agree to Schedule V, line 17, col. 1)				Other Benefits	19,184		204	
(List each licensed administrator separately.)			\$ 110,978				3,891	
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	(3,574)	
			\$			Non-allowable advertising	(204)	
						Yellow page advertising	()	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 471,826	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,786	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Heritage Operations Group	Management	\$	210,325					
A Place For Mom	Resident referrals		1,966					
Old Second Nat'l Bank	Investment fees		16,812					
Weber & Associates	Bookkeeping services		1,175				In-State Travel	
Dugan & Lopatka	Audit and Tax services		4,900					1,599
First Class Solutions	Medical records consulting		247					122
Tracye Young	MDS consulting		4,100					
ADP	Payroll tax reporting		377				Seminar Expense	1,210
								0
Legal adj to Zero			5,350				Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		TOTAL	\$ 2,931
(For legal fee disclosure, see page 39 of instructions)			\$ 245,252					

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. NA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? NA
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 145,672
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,048
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Dugan & Lopatka
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees.

HHS-2745 (9-4-00)L478-2671

Jennings Terrace Inc.
2020 Cost Report
Supplemental Schedules
Reclassification Entries

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

<u>Line Item</u>	
Purchased Drugs and Medications	\$ 6,121
Purchased Hospital Services	0
Purchased Laboratory Services	0
Purchased Radiology Services	0
Amount Reclassified to Line 39	\$ <u>6,121</u>

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

<u>Line Item</u>	
Provider Participation Fee - \$1.50	\$ (32,940)
Provider Assesment Fee - \$6.07	<u>(112,732)</u>
	<u>(145,672)</u>
Provider Participation Fee	<u>145,672</u>