

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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>07/01/24</u> to <u>06/30/25</u> and certify to the best of my knowledge and belief that the said content 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	
Address: <u>275 South LaSalle</u> <u>Aurora</u> <u>60505</u> Number City Zip Code		Intentional misrepresentation or falsification of any informatior in this cost report may be punishable by fine and/or imprisonment	
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>07/05/43</u>			
Type of Ownership:			
☒ VOLUNTARY, NON-PROFIT			
☒ Charitable Corp.			
☐ Trust			
IRS Exemption Code <u>501 (c) 3</u>			
☐ PROPRIETARY			
☐ Individual			
☐ Partnership			
☐ Corporation			
☐ "Sub-S" Corp.			
☐ Limited Liability Co.			
☐ Trust			
☐ Other _____			
☐ GOVERNMENTAL			
☐ State			
☐ County			
☐ Other _____			
In the event there are further questions about this report, please contact: Name: <u>Joseph Kenny, Outside Preparer</u>		Officer or Administrator of Provider	
Telephone Number: <u>312-203-1771</u>		(Signed) _____ <u>02/10/26</u> (Date)	
Email Address: _____		(Type or Print Name) <u>JoMarie Silver</u>	
		(Title) <u>Administrator</u>	
		Paid Preparer	
		(Signed) _____ <u>02/10/26</u> (Date)	
		(Print Name and Title) <u>Joseph Kenny, CPA, CMA, CCRS</u> <u>Partner</u>	
		(Firm Name & Address) <u>Paisley & Elm, LLC</u> <u>1724 West Berwyn Ave, 1F, Chicago, IL 60640</u>	
		(Telephone) <u>312-203-1771</u> Fax # <u>312-275-7967</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630	

Facility Name & ID Number Jennings Terrace# 0010371Report Period Beginning: 07/01/24 Ending: 06/30/25

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>60</u>	Skilled (SNF)	<u>60</u>	<u>21,900</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>104</u>	Sheltered Care (SC)	<u>104</u>	<u>37,960</u>	5
6		ICF/DD 16 or Less			6
7	<u>164</u>	TOTALS	<u>164</u>	<u>59,860</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI Medicaid Primary	Medicare Primary	Private Pay	Medicare Part A Only	Other	Total	
8	SNF	<u>4,893</u>	<u>2,059</u>	<u>3,683</u>	<u>0</u>		<u>475</u>	<u>5,241</u>	<u>16,351</u>	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC							<u>12,285</u>	<u>12,285</u>	12
13	DD 16 OR LESS									13
14	TOTALS	<u>4,893</u>	<u>2,059</u>	<u>3,683</u>			<u>475</u>	<u>17,526</u>	<u>28,636</u>	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed
bed days on column 4, line 7.) 47.84%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)
NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 07/05/1943J. 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 certified beds.
number of certified beds 60Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 07/01/24 Fiscal Year: 06/30/25

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

07/01/24

Ending:

06/30/25

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	
1	Dietary	444,044	632	10,646	455,322		455,322	(1,122)	454,200			1
2	Food Purchase		298,197		298,197		298,197		298,197			2
3	Housekeeping	157,311	6,258		163,569		163,569		163,569			3
4	Laundry	37,096	4,032		41,128		41,128		41,128			4
5	Heat and Other Utilities			202,369	202,369		202,369		202,369			5
6	Maintenance	116,478		89,348	205,826		205,826		205,826			6
7	Other (specify):*											7
8	TOTAL General Services	754,929	309,119	302,363	1,366,411		1,366,411	(1,122)	1,365,289			8
9	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,921,767	178,872	63,061	2,163,700		2,163,700		2,163,700			10
10a	Therapy											10a
11	Activities	63,214	4,122		67,336		67,336		67,336			11
12	Social Services	74,547		3,604	78,151		78,151		78,151			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,059,528	182,994	72,665	2,315,187		2,315,187		2,315,187			16
17	C. General Administration											
17	Administrative	122,635			122,635		122,635		122,635			17
18	Directors Fees											18
19	Professional Services			112,584	112,584		112,584	(22,807)	89,777			19
20	Dues, Fees, Subscriptions & Promotions			5,547	5,547		5,547		5,547			20
21	Clerical & General Office Expenses	176,721	7,232	452,672	636,625		636,625	(231,840)	404,785			21
22	Employee Benefits & Payroll Taxes			481,816	481,816		481,816		481,816			22
23	Inservice Training & Education											23
24	Travel and Seminar			370	370		370		370			24
25	Other Admin. Staff Transportation			212,882	212,882		212,882		212,882			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	299,356	7,232	1,265,871	1,572,459		1,572,459	(254,647)	1,317,812			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,113,813	499,345	1,640,899	5,254,057		5,254,057	(255,769)	4,998,288			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:

07/01/24

Ending:

06/30/25

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			178,266	178,266		178,266		178,266			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			236,358	236,358		236,358		236,358			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,795	40,795		40,795		40,795			35
36	Other (specify):*											36
37	TOTAL Ownership			455,419	455,419		455,419		455,419			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Centers		30,823	212,966	243,789		243,789		243,789			39
40	Barber and Beauty Shops	430		502	932		932	(932)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			342,572	342,572		342,572		342,572			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers	430	30,823	556,040	587,293		587,293	(932)	586,361			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,114,243	530,168	2,652,358	6,296,769		6,296,769	(256,701)	6,040,068			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	(1,098)	1	4
5	Telephone, TV & Radio in Resident Rooms	(6,917)	21	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	(10,761)	21	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			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions			20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainer			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt	(213,131)	21	24
25	Fund Raising, Advertising and Promotional			25
26	Income Taxes and Illinois Personal			26
27	Property Replacement Tax			27
28	CNA Training for Non-Employees			28
29	Yellow Page Advertising			29
30	Other-Attach Schedule			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (231,907)		\$ 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))	\$ (231,907)	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			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

Jennings Terrace

ID# 0010371

Report Period Beginning: 07/01/24

Ending: 06/30/25

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Public Relations	(1,031)	21	3
4	Beauty Shop	(932)	40	4
5	Meals	(24)	1	5
6	Lobbying Costs	(22,807)	19	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(24,794)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Jennings Terrace# 0010371

Report Period Beginning:

07/01/24

Ending:

06/30/25

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,122)	0	0	0	0	0	0	0	0	0	0	(1,122)	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	(1,122)	0	0	0	0	0	0	0	0	0	0	(1,122)	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	(22,807)	0	0	0	0	0	0	0	0	0	0	(22,807)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(231,840)	0	0	0	0	0	0	0	0	0	0	(231,840)	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	(254,647)	0	0	0	0	0	0	0	0	0	0	(254,647)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(255,769)	0	0	0	0	0	0	0	0	0	0	(255,769)	29

Summary B

06/30/25

[illegible]

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 ownership supplemental Tabs						

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

☐ YES ☐ NO

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

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

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

VII. RELATED PARTIES (continued)

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

☐

YES

☒

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
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)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

VII. RELATED PARTIES
A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/24 Ending: 06/30/25

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									\$		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:

07/01/24Ending: 06/30/25

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

Facility Name & ID Number Jennings Terrace# 0010371

Report Period Beginning:

07/01/24Ending: 06/30/25

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

Facility Name & ID Number Jennings Terrace # 0010371 Report Period Beginning: 07/01/24 Ending: 06/30/25

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													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

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

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

2024 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 2024 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 2024.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <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 copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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. List the bed capacity for the building if it differs from the licensed total

N/A

G. Have you properly capitalized all major repairs and equipment purchases?

Yes

H. Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

I. Are you presently operating under a sublease agreement?

J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

☒ If YES, please indicate name of the facility.

IDPH license number of this related party and the date the present owners took over.

N/A

K. 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	Facility	475,304	Various	\$ 574,906	1
2					2
3	TOTALS	475,304		\$ 574,906	3

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

07/01/24

Ending:

06/30/25

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	104		1961	1961	\$ 603,512	\$	40	\$		\$ 603,512	4
5	60		1985	1985	1,863,135		40	46,578	46,578	1,847,602	5
6											6
7											7
8											8
	Improvement Type**										
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		40	109	109	3,847	11
12	Building Improvement			1992	4,550		15			4,550	12
13	Building Improvement			1993	7,238		15			7,238	13
14	Building Improvement			1994	4,677		15			4,677	14
15	Building Improvement			1996	98,189		15			98,189	15
16	Building Improvement			1998	3,243		10			3,243	16
17	Building Improvement			1999	8,049		40	201	201	6,713	17
18	Building Improvement			2000	52,261		40	1,307	1,307	42,469	18
19	Building Improvement			2001	11,027		40	276	276	9,793	19
20	Building Improvement			2002	14,456		15			14,456	20
21	Building Improvement			2003	7,541		15			7,541	21
22	Building Improvement			2005	13,050		10			13,050	22
23	Building Improvement			2006	7,157		10			7,157	23
24	Building Improvement			2007	24,900		10			24,900	24
25	Building Improvement			2008	59,940		15			59,940	25
26	Building Improvement			2009	15,332		10			15,332	26
27	Building Improvement			2010	9,033		5			9,033	27
28	Building Improvement			2011	48,839		15			48,839	28
29	Building Improvement			2012	98,850		15	6,590	6,590	96,910	29
30	Building Improvement			2013	4,000		10			4,000	30
31	Building Improvement			2014	41,170		10	2,047	2,047	43,205	31
32	Building Improvement			2015	55,173		10	5,517	5,517	57,930	32
33	Building Improvement			2016	38,037		10	3,804	3,804	36,137	33
34	Building Improvement			2016	28,175		15	1,878	1,878	17,843	34
35	Building Improvement			2016	2,895		5			2,895	35
36											36

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

See Page 12A, Line 70 for total

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

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,172,548	\$		\$ 68,307	\$ 68,307	\$ 3,134,744	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:

07/01/24

Ending:

06/30/25

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		\$ 3,172,548	\$		\$ 68,307	\$ 68,307	\$ 3,134,744	1
2	BUILDING IMP - ROOF	2017	42,086		10	4,209	4,209	35,775	2
3	BUILDING IMP - KITCHEN FLOORIN	2017	13,000		10	1,300	1,300	11,050	3
4	BUILDING IMP - PAVILLION CONCR	2017	5,418		10	542	542	4,607	4
5	BUILDING IMP - WINDOWS	2017	6,775		10	678	678	5,762	5
6	BUILDING IMP - CHILLER PUMP	2017	6,393		10	639	639	5,433	6
7	BUILDING IMP - GAZEBO	2017	4,320		10	432	432	3,672	7
8	BUILDING IMP - SPRINKLER SYST	2018	6,533		10	653	653	4,899	8
9	BUILDING IMP - WINDOW TREATM	2018	10,000		40	250	250	1,875	9
10	BUILDING IMP - PAINTING	2018	30,080		15	2,005	2,005	15,039	10
11	BUILDING IMP - ASBESTOS REMO	2018	50,480		40	1,262	1,262	9,465	11
12	BUILDING IMP - FLOORING	2018	121,371		40	3,034	3,034	22,756	12
13	BUILDING IMP - ELECTRICAL UPGR	2018	66,666		40	1,667	1,667	12,502	13
14	BUILDING IMP - BOILER	2018	14,669		40	367	367	2,751	14
15	BUILDING IMP - DUMBWAITER	2018	2,500		40	63	63	471	15
16	BUILDING IMP - AIR HANDLER	2019	20,643		15	1,376	1,376	8,753	16
17	BUILDING IMP - DUMBWAITER	2019	30,706		40	768	768	4,991	17
18	BUILDING IMP - CARPET AND VINY	2019	20,151		10	2,015	2,015	13,098	18
19	BUILDING IMP - SIGN	2019	20,740		40	519	519	3,372	19
20	BUILDING IMP - WATER HEATERS	2019	5,000		10	500	500	3,250	20
21	BUILDING IMP - GARAGE/BOOSTE	2019	4,225		10	423	423	2,748	21
22	BUILDING IMP - CARPET SQUARE	2019	9,150		10	915	915	5,948	22
23	BUILDING IMP - FLOORING	2019	12,307		10	1,231	1,231	7,077	23
24	BUILDING IMP - SPRINKLER	2019	9,185		10	919	919	5,359	24
25	BUILDING IMP - DUMBWAITER	2019	9,300		40	233	233	1,358	25
26	BUILDING IMP - DATA CABLING	2019	16,995		10	1,700	1,700	9,774	26
27	BUILDING IMP - CHEM INJ PUMP	2019	3,895		10	390	390	2,209	27
28	BUILDING IMP - PUMP REBUILD	2020	3,685		10	369	369	1,998	28
29	BUILDING IMP - HVAC	2020	8,718		10	872	872	4,651	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,727,539	\$		\$ 97,633	\$ 97,633	\$ 3,345,387	34

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

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

07/01/24

Ending:

06/30/25

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 12B, Carried Forward		\$ 3,727,539	\$		\$ 97,633	\$ 97,633	\$ 3,345,387	1
2	LAND IMP - PARKING LOT	1974	470		7			470	2
3	LAND IMP - PARKING LOT	1985	880		7			880	3
4	LAND IMP - PARKING LOT	1992	7,445		10			7,445	4
5	LAND IMP - PARKING LOT - BLACK	2001	7,549		10			7,549	5
6	LAND IMP - PARKING LOT - FRON	2003	30,959		10			30,959	6
7	LAND IMP - PARKING LOT - LIGHT	2010	3,518		10			3,518	7
8	LAND IMP - PARKING LOT - RESU	2013	6,389		10			6,389	8
9	LAND IMP - VARIOUS	1978	2,317		10			2,317	9
10	LAND IMP - VARIOUS	1982	1,007		10			1,007	10
11	LAND IMP - VARIOUS	1988	4,084		10			4,084	11
12	LAND IMP - YARD LIGHTS	1989	1,390		15			1,390	12
13	LAND IMP - SIDEWALK	1990	1,450		10			1,450	13
14	LAND IMP - SIDEWALK	1991	600		10			600	14
15	LAND IMP - SIDEWALK	1994	440		10			440	15
16	LAND IMP - SIDEWALK	1998	1,592		10			1,592	16
17	LAND IMP - SIDEWALK	2002	225		10			225	17
18	LAND IMP - FENCE	2003	3,581		10			3,581	18
19	LAND IMP - FENCE	2004	4,353		10			4,353	19
20	LAND IMP - TREE REMOVAL/CON	2005	15,812		10			15,812	20
21	LAND IMP - TERRACE	2010	35,935		15	1,195	1,195	35,935	21
22	LAND IMP - CONCRETE WORK	2011	3,332		10			3,332	22
23	LAND IMP - EASTSIDE ENTRY	2014	6,400		10			6,400	23
24	LAND IMP - LANDSCAPING	2018	15,410		10	1,541	1,541	10,278	24
25	LAND IMP - PARKING LOT - SOUTH	2024	113,400		10	5,670	5,670	11,340	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,996,077	\$		\$ 106,039	\$ 106,039	\$ 3,506,733	34

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

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

07/01/24

Ending:

06/30/25

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,996,077	\$		\$ 106,039	\$ 106,039	\$ 3,506,733	1
2									2
3	EQUIPMENT VARIOUS		290,728		40	7,268	7,268	136,775	3
4	EQUIPMENT VARIOUS		89,885		10	8,989	8,989	60,354	4
5	FULLY DEPRECIATED ASSETS VARIOUS		849,969		10			849,969	5
6	RESIDENTIAL/STAFF TRANSPOR	2009	48,491		10			48,491	6
7	LIGHT FIXTURE	2019	1,500		7	214	214	1,196	7
8	AIR CONDITIONER	2019	5,395		7	771	771	4,304	8
9	MEDICAL EQUIPMENT	2020	4,744		7	678	678	3,671	9
10	MILNOR WASHER	2020	12,345		7	1,764	1,764	8,819	10
11	NETWORK INFRASTRUCTURE EQU	2019	27,756		7	3,965	3,965	23,790	11
12	CONVECTION STEAMER	2020	8,560		7	1,223	1,223	5,911	12
13	MEAL CART DELIVERY SYSTEM	2020	5,865		7	838	838	3,841	13
14	MISC EQUIPMENT	2022	17,195		7	2,456	2,456	7,078	14
15	NURSE STATION LAPTOP	2024	1,470		5	294	294	392	15
16	TIME CLOCK	2024	1,375		5	275	275	275	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	TOTAL (lines 1 thru 33)		\$ 5,361,355	\$		\$ 134,774	\$ 134,774	\$ 4,661,599	34

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

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

07/01/24

Ending:

06/30/25

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 12D, Carried Forward		\$ 5,361,355	\$		\$ 134,774	\$ 134,774	\$ 4,661,599	1
2	BUILDING IMP - FIRE DETECTION	2020	43,212		15	2,881	2,881	14,405	2
3	BUILDING IMP - MINI SPLIT	2020	5,495		10	550	550	2,841	3
4	BUILDING IMP - DINING AC	2020	26,975		10	2,698	2,698	13,714	4
5	BUILDING IMP - WALK IN FRIDGE	2020	5,444		10	544	544	2,766	5
6	NURSE CALL STATION - SOUTH W	2020	11,115		10	1,112	1,112	5,373	6
7	CHEMICAL TREATMENT SYSTEM	2020	6,745		10	675	675	3,317	7
8	KITCHEN BOOSTER HEATER	2021	2,550		10	255	255	1,041	8
9	MAIN ENTRANCE SECURITY ENHA	2021	6,947		10	695	695	2,953	9
10	NEW ROOF	2021	245,771		10	24,577	24,577	108,548	10
11	WATER HEATER	2020	4,475		10	448	448	2,052	11
12	CHILLER	2023	36,569		10	3,657	3,657	8,228	12
13	BUILDING ADDITIONS	2021	26,465		10	2,647	2,647	9,484	13
14	BOILER TUBES	2022	26,460		10	2,646	2,646	7,277	14
15	WANDERGUARD CONTOLLER	2023	2,186		10	109	109	219	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	TOTAL (lines 1 thru 33)		\$ 5,811,764	\$		\$ 178,265	\$ 178,265	\$ 4,843,817	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	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)	\$ 6,386,670	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 178,265	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 178,265	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,843,817	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Jennings Terrace

Report Period Beginning: 07/01/24

Ending: 06/30/25

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

☐ YES ☐ NO

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ Description:

☐ YES ☐ NO

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. 2026 \$

13. _____ /**2027** \$ _____

14. _____ /2028 \$ _____

*** 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: 07/01/24 Ending: 06/30/25
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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	

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

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	V39	hrs	\$		1,006	\$ 79,909	\$	1,006	\$ 79,909	1
2	Licensed Speech and Language Development Therapist	V39	hrs			177	20,258		177	20,258	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	V39	hrs			1,438	100,080	4,716	1,438	104,796	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify): Labs/Xrays and Billable Supplies						8,024			8,024	13
14	TOTAL			\$		2,621	\$ 208,271	\$ 4,716	2,621	\$ 212,987	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 115,503	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,772,870		3
4 Supply Inventory (priced at)	44,078		4
5 Short-Term Investments	199,815		5
6 Prepaid Insurance	203,252		6
7 Other Prepaid Expenses			7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
TOTAL Current Assets			
10 (sum of lines 1 thru 9)	\$ 3,335,518	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	574,906		13
14 Buildings, at Historical Cost	4,446,486		14
15 Leasehold Improvements, at Historical Cos			15
16 Equipment, at Historical Cost	1,365,278		16
17 Accumulated Depreciation (book methods)	(4,848,567)		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
TOTAL Long-Term Assets			
24 (sum of lines 11 thru 23)	\$ 1,538,103	\$	24
TOTAL ASSETS			
25 (sum of lines 10 and 24)	\$ 4,873,621	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 572,235	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	4,221		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	280,209		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36			36
37			37
TOTAL Current Liabilities			
38 (sum of lines 26 thru 37)	\$ 856,665	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	1,575,705		39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities			
45 (sum of lines 39 thru 44)	\$ 1,575,705	\$	45
TOTAL LIABILITIES			
46 (sum of lines 38 and 45)	\$ 2,432,370	\$	46
TOTAL EQUITY (page 18, line 24)	\$ 2,441,251	\$	47
TOTAL LIABILITIES AND EQUITY			
48 (sum of lines 46 and 47)	\$ 4,873,621	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,068,618	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,068,618	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(627,367)	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)	\$ (627,367)	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)	\$ 2,441,251	24

* This must agree with page 17, line 47.

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning:

07/01/24

Ending:

06/30/25

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	3,726	3,726	\$ 104,665	\$ 28.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,724	8,724	521,113	59.73	3
4	Licensed Practical Nurses	8,385	8,385	350,166	41.76	4
5	CNAs & Orderlies	41,839	41,839	945,823	22.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,189	4,189	63,214	15.09	9
10	Activity Assistants					10
11	Social Service Workers	2,023	2,023	74,517	36.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,865	24,865	444,044	17.86	15
16	Dishwashers					16
17	Maintenance Workers	5,790	5,790	116,478	20.12	17
18	Housekeepers	8,098	8,098	157,311	19.43	18
19	Laundry	2,295	2,295	37,096	16.16	19
20	Administrator	2,080	2,080	122,635	58.96	20
21	Assistant Administrator					21
22	Other Administrative	6,205	6,205	176,721	28.48	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)	118,219	118,219	\$ 3,113,783 *	\$ 26.34	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		\$		35
36	Medical Director	Monthly Fees	6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				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	Monthly Fees	3,604	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,604		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Jennings Terrace

0010371

Report Period Beginning: 07/01/24

Ending:

06/30/25

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	\$ 6,139,561	1
2	Discounts and Allowances for all Levels	(658,810)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,480,751	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	863	13
14	Non-Patient Meals	1,098	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,961	23
	D. Non-Operating Revenue		
24	Contributions	12,541	24
25	Interest and Other Investment Income***	12,421	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 24,962	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	161,728	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 161,728	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,669,402	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,366,411	31
32	Health Care	2,315,187	32
33	General Administration	1,572,459	33
	B. Capital Expense		
34	Ownership	455,419	34
	C. Ancillary Expense		
35	Special Cost Centers	244,721	35
36	Provider Participation Fee	342,572	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,296,769	40
41	Income before Income Taxes (line 30 minus line 40)**	(627,367)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (627,367)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,173,855.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	493,932.00	45
46	MMAI-Medicaid is the Primary Payer	883,516.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	826,977.00	48
49	Medicare Part A	602,915.00	49
50	Other-(specify) Shelter Care	651,571.00	50
51	Other-(specify) Ancillary	847,985.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,480,751	56

- (15) 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.