

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>0047290</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>North Kickapoo</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/12</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.	
Address: <u>1903 N Kickapoo St Bx 511</u> <u>Lincoln</u> <u>62656</u>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Logan</u>			
Telephone Number: <u>217-428-7463</u> Fax # <u>217-422-6365</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>12/19/2006</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☒ "Sub-S" Corp.	
		☐ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Jeremy Maupin</u>			
Telephone Number: <u>217-422-6361</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Jeremy Maupin</u>	
		(Title) <u>President</u>	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>Larry Templin</u> <u>Partner</u>	
		(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>	
		(Telephone) <u>630-361-2868</u> Fax # () _____	
		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 North Kickapoo# 0047290 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,719			5,719	13
14	TOTALS	5,719			5,719	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 97.66%

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

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

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

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

None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒Non-allowable costs have been
eliminated in Schedule V, Column 7

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 09/16/05

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 9/16/05NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	45,172	1,336	1,270	47,778		47,778		47,778		1
2	Food Purchase		31,232		31,232		31,232		31,232		2
3	Housekeeping	22,342	15,720		38,062		38,062		38,062		3
4	Laundry		731		731		731		731		4
5	Heat and Other Utilities			13,385	13,385		13,385		13,385		5
6	Maintenance		3,575	15,478	19,053		19,053	281	19,334		6
7	Other (specify):* Waste Removal			1,482	1,482		1,482		1,482		7
8	TOTAL General Services	67,514	52,594	31,615	151,723		151,723	281	152,004		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	167,996	10,018	5,081	183,095		183,095		183,095		10
10a	Therapy			1,478	1,478		1,478		1,478		10a
11	Activities	21,560	8,394		29,954		29,954		29,954		11
12	Social Services										12
13	CNA Training	13,496			13,496		13,496		13,496		13
14	Program Transportation			8,627	8,627		8,627	(780)	7,847		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	203,052	18,412	22,386	243,850		243,850	(780)	243,070		16
	C. General Administration										
17	Administrative	31,945		16,200	48,145		48,145	(930)	47,215		17
18	Directors Fees										18
19	Professional Services			8,465	8,465		8,465	382	8,847		19
20	Dues, Fees, Subscriptions & Promotions			1,949	1,949		1,949	297	2,246		20
21	Clerical & General Office Expenses		4,846	7,306	12,152		12,152		12,152		21
22	Employee Benefits & Payroll Taxes			53,340	53,340		53,340	1,450	54,790		22
23	Inservice Training & Education			441	441		441		441		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			3,608	3,608		3,608		3,608		25
26	Insurance-Prop.Liab.Malpractice			10,356	10,356		10,356	97	10,453		26
27	Other (specify):*										27
28	TOTAL General Administration	31,945	4,846	101,665	138,456		138,456	1,296	139,752		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	302,511	75,852	155,666	534,029		534,029	797	534,826		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			5,258	5,258		5,258	15,501	20,759			30
31	Amortization of Pre-Op. & Org.			35,000	35,000		35,000	(35,000)				31
32	Interest			18,532	18,532		18,532	17,128	35,660			32
33	Real Estate Taxes			11,114	11,114		11,114	(210)	10,904			33
34	Rent-Facility & Grounds			36,204	36,204		36,204	(36,204)				34
35	Rent-Equipment & Vehicles			5,693	5,693		5,693	65	5,758			35
36	Other (specify):*											36
37	TOTAL Ownership			111,801	111,801		111,801	(38,720)	73,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			158,265	158,265		158,265		158,265			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,394	43,394		43,394		43,394			42
43	Other (specify):* Non-allowable Costs			1,000	1,000		1,000	(1,000)				43
44	TOTAL Special Cost Centers			202,659	202,659		202,659	(1,000)	201,659			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	302,511	75,852	470,126	848,489		848,489	(38,923)	809,566			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				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	(210)	33		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,000)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(35,780)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,990)		\$	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)	(1,933)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,933)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (38,923)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

North Kickapoo

Report Period Beginning: ID# 0047290

Ending: 1/1/2012

12/31/12

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Offset Transportation Income	\$ (780)	14	1
2	Disallow Amortization	(35,000)	31	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(35,780)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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	281	0	0	0	0	0	0	0	0	0	281	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	281	0	0	0	0	0	0	0	0	0	281	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	(780)	0	0	0	0	0	0	0	0	0	0	(780)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(780)	0	0	0	0	0	0	0	0	0	0	(780)	16
	C. General Administration													
17	Administrative	0	(930)	0	0	0	0	0	0	0	0	0	(930)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	382	0	0	0	0	0	0	0	0	0	382	19
20	Fees, Subscriptions & Promotions	0	297	0	0	0	0	0	0	0	0	0	297	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	1,450	0	0	0	0	0	0	0	0	0	1,450	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	97	0	0	0	0	0	0	0	0	0	97	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	1,296	0	0	0	0	0	0	0	0	0	1,296	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(780)	1,577	0	0	0	0	0	0	0	0	0	797	29

Summary B

12/31/12

[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
Jeremy Maupin	100	Hickory Point Terrace	Forsyth	J&J Maupin Enterprises	Decatur, IL	Real Estate
		Spring Creek Terrace	Decatur	A Step Forward	Decatur, IL	Day Training
		Burgener Drive	Decatur			

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

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 36,204	J&J Maupin Enterprises	100.00%	\$	(36,204)	1
2	V	6	Maintenance		J&J Maupin Enterprises	100.00%	281	281	2
3	V	17	Administrative	16,200	J&J Maupin Enterprises	100.00%	15,270	(930)	3
4	V	19	Professional Fees		J&J Maupin Enterprises	100.00%	382	382	4
5	V	20	Dues, Subscriptions, Licenses		J&J Maupin Enterprises	100.00%	297	297	5
6	V	22	Employee Benefits		J&J Maupin Enterprises	100.00%	1,450	1,450	6
7	V	26	Insurance		J&J Maupin Enterprises	100.00%	97	97	7
8	V	30	Depreciation		J&J Maupin Enterprises	100.00%	15,501	15,501	8
9	V	32	Interest		J&J Maupin Enterprises	100.00%	17,128	17,128	9
10	V	35	Rent-Equipment		J&J Maupin Enterprises	100.00%	65	65	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 52,404			\$ 50,471	\$ * (1,933)	14

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

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	Jeremy Maupin	President	Administrative	100.00	38,636	15	25.00	Salary	\$ 18,297	L17, C1 & 7	1
2	Jennifer Maupin	Controller	Other Admin	0.00	7,342	10	33.33	Salary	3,358	L17, C1 & 7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,655		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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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 J&J Maupin Enterprises
Street Address 5310 E. William Street Road
City / State / Zip Code Decatur, IL 62521
Phone Number (217-422-6361
Fax Number (217-422-6365

	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	6	Maintenance	Revenue	3,257,229	4	\$ 1,043	\$	878,090	\$ 281	1
2	17	Administrative	Revenue	3,257,229	4	56,641	56,641	878,090	15,270	2
3	19	Professional Fees	Revenue	3,257,229	4	1,418		878,090	382	3
4	20	Dues, Subscriptions, Licenses	Revenue	3,257,229	4	1,100		878,090	297	4
5	22	Employee Benefits	Revenue	3,257,229	4	5,378		878,090	1,450	5
6	26	Insurance	Revenue	3,257,229	4	362		878,090	97	6
7	30	Depreciation	Revenue	3,257,229	4	57,498		878,090	15,501	7
8	32	Interest	Revenue	3,257,229	4	63,534		878,090	17,128	8
9	35	Rent-Equipmt	Revenue	3,257,229	4	240		878,090	65	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					\$ 187,214	\$ 56,641		\$ 50,471	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	First Mid IL Bank & Trust		X	Facility	\$3,388.74	10/26/05	\$ 366,667	\$ 139,839	9/26/2015	4.2500	\$ 6,226	1	
2	Vehicle Loan		X	Vehicle	\$262.19	5/3/07	13,528		5/3/2012	6.0000	122	2	
3												3	
4												4	
5												5	
	Working Capital												
6	First Mid IL Bank & Trust		X	Line of Credit		9/26/09			11/12/12	6.0000	6,015	6	
7	Kim Robinson		X	Working Capital	\$1,130.44	9/16/05	170,000	103,309	8/16/2015	6.5000	6,169	7	
8												8	
9	TOTAL Facility Related				\$4,781.37		\$ 550,195	\$ 243,148			\$ 18,532	9	
	B. Non-Facility Related*												
10												10	
11								Home Office allocation			17,128	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 17,128	14	
15	TOTALS (line 9+line14)						\$ 550,195	\$ 243,148			\$ 35,660	15	

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2011	\$10,904	2
3. Under or (over) accrual (line 2 minus line 1).			\$10,904	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$10,904	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2007	10,064	8	
	2008	10,064	9	
	2009	10,738	10	
	2010	10,626	11	
	2011	10,904	12	
Accrual based on prior year tax bill.				

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Kickapoo COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0047290

CONTACT PERSON REGARDING THIS REPORT Jeremy Maupin

TELEPHONE 217-422-6361 FAX #: 217-422-6365

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>08-029-015-50</u>	<u>Facility</u>	\$ <u>10,904.00</u>	\$ <u>10,904.00</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>10,904.00</u></u>	\$ <u><u>10,904.00</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 X NO

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 5,000

B. General Construction Type: Exterior Brick/Vinyl Frame Wood

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: N/A

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				\$	1
2					2
3	TOTALS			\$	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Parking Lot		2009		500	33	15	33		84
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21	Allocated from J & J Maupin Enterprises							15,501	15,501	
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

*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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		\$ 500	\$ 33		\$ 15,534	\$ 15,501	\$ 84	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$69,179	\$3,506	\$3,506		5-7 yr	\$53,259	71
72	Current Year Purchases	5,231	523	523		5 yrs	523	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$74,410	\$4,029	\$4,029			\$53,782	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	Program Transportation	2002 Dodge Caravan	2005	\$2,500	\$	\$		5 yr	\$2,500	76
77	Program Transportation	2006 Dodge Caravan	2007	18,523	1,196	1,196		5 yr	18,523	77
78										78
79										79
80	TOTALS			\$21,023	\$1,196	\$1,196			\$21,023	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$95,93381
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$5,25882
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$20,75983**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$15,50184
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$74,88985

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	N/A				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: _____
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☒ NO
- If NO, see instructions.

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2013 \$ _____
13. _____/2014 \$ _____
14. _____/2015 \$ _____

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

This amount was calculated by dividing the total amount to be amortized _____

by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 65 Description: Allocated from J & J Enterprises
- (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	Resident	2011 Toyota Sienna	\$ 569.34	\$ 5,693	17
18					18
19					19
20					20
21	TOTAL		\$ 569.34	\$ 5,693	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 CNA40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒
IN OTHER FACILITY☐
HOURS PER CNA80

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)		13,496		13,496
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 13,496	\$	\$ 13,496
10	SUM OF line 9, col. 1 and 2 (e)	\$	13,496		

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	7

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

12345678										
	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	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Day Training	39 (3)				158,265			158,265	13
14	TOTAL			\$		\$ 158,265	\$		\$ 158,265	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 30,722	\$ 30,722	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	137,027	137,027	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	19,478	19,478	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 187,227	\$ 187,227	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	500	500	15
16	Equipment, at Historical Cost	95,433	95,433	16
17	Accumulated Depreciation (book methods)	(74,889)	(74,889)	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: Goodwill)	271,250	271,250	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 292,294	\$ 292,294	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 479,521	\$ 479,521	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 44,553	\$ 44,553	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,421	14,421	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	858	858	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 59,832	\$ 59,832	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	103,309	103,309	39
40	Mortgage Payable	139,839	139,839	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)	\$ 243,148	\$ 243,148	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 302,980	\$ 302,980	46
47	TOTAL EQUITY(page 18, line 24)	\$ 176,541	\$ 176,541	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 479,521	\$ 479,521	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 164,140	1
2	Restatements (describe):		2
3			3
4	Prior period adjustment	(1,300)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 162,840	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	29,601	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	(15,900)	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)	\$ 13,701	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)	\$ 176,541	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number North Kickapoo# 0047290Report Period Beginning: 1/1/2012Ending: 12/31/12

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 717,761	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 717,761	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		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		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Workshop Revenue	158,265	28
28a	EIC \$1284, Transportation Income \$780	2,064	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 160,329	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 878,090	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	151,723	31
32	Health Care	243,850	32
33	General Administration	138,456	33
	B. Capital Expense		
34	Ownership	111,801	34
	C. Ancillary Expense		
35	Special Cost Centers	159,265	35
36	Provider Participation Fee	43,394	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 848,489	40
41	Income before Income Taxes (line 30 minus line 40)**	29,601	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 29,601	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 717,761	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)	\$ 717,761	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? Yes 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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	693	693	17,947	25.90	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	1,535	1,535	13,496	8.79	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,792	1,878	19,721	10.50	9
10	Activity Assistants	199	199	1,839	9.24	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,771	4,080	45,172	11.07	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,775	1,976	22,342	11.31	18
19	Laundry					19
20	Administrator	227	227	5,323	23.45	20
21	Assistant Administrator					21
22	Other Administrative	1,189	1,213	26,622	21.95	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,080	2,080	43,404	20.87	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	10,777	11,095	106,645	9.61	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,038	24,976	\$ 302,511 *	\$ 12.11	34

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	Monthly	\$ 1,270	L1, C3	35
36	Medical Director	Monthly	7,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,250	L10, C3	38
39	Pharmacist Consultant	Monthly	372	L10, C3	39
40	Physical Therapy Consultant	Monthly	650	L10a, C3	40
41	Occupational Therapy Consultant	Monthly	162	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	666	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	718	L10, C3	46
47	Psychologist	Monthly	1,425	L10, C3	47
48	Podiatry	Monthly	1,316	L10, C3	48
49	TOTAL (lines 35 - 48)		\$ 15,029		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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

** See instructions.

Facility Name & ID Number		North Kickapoo		STATE OF ILLINOIS		# 0047290		Report Period Beginning:		1/1/2012		Page 21		Ending:		12/31/12	
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				Ownership				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name		Function		%		Amount		Description		Amount		Description		Amount			
Jeremy Maupin		Administrative		100		\$ 5,323		Workers' Compensation Insurance		\$ 9,794		IDPH License Fee		\$			
Jennifer Maupin		Other Admin		0		1,262		Unemployment Compensation Insurance		3,389		Advertising: Employee Recruitment				526	
Kristi Nottelmann		Other Admin		0		25,360		FICA Taxes		18,680		Health Care Worker Background Check				975	
								Employee Health Insurance		6,331		(Indicate # of checks performed 75)					
								Employee Meals		15,146		Patient Background Checks					
								Illinois Municipal Retirement Fund (IMRF)*				Licenses and Fees				448	
TOTAL (agree to Schedule V, line 17, col. 1)								Allocated from J & J Maupin Enterprises		1,450		Allocated from J & J Maupin Enterprises				297	
(List each licensed administrator separately.)						\$ 31,945											
B. Administrative - Other																	
Description						Amount											
Management Fees - Eliminated in Col. 7						\$ 16,200											
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 16,200		TOTAL (agree to Schedule V,		\$ 54,790		TOTAL (agree to Sch. V,		\$ 2,246			
(Attach a copy of any management service agreement)								line 22, col.8)				line 20, col. 8)					
C. Professional Services								E. Schedule of Non-Cash Compensation Paid				G. Schedule of Travel and Seminar**					
Vendor/Payee		Type				Amount		Description		Line #		Amount		Description		Amount	
Martin, Hood, Friese & Associates, I		Accounting				\$ 3,050						\$		Out-of-State Travel		\$	
Kelly's Accounting		Accounting				5,156											
Quickbooks		Payroll Service				259											
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL		\$				Seminar Expense			
(If total legal fees exceed \$5,000, attach copy of invoices.)						\$ 8,465								N/A			
														Entertainment Expense		(	
														(agree to Sch. V,			
														TOTAL		\$	
														line 24, col. 8)			

* Attach copy of IMRF notifications

**See instructions.

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

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

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.

N/A

(3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5 yrs

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

1,276

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.

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

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

YES

NO

X

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

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

43,394

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?

Yes

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.

\$

15,146

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

N/A

(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.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

33

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?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A

(17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

(18)

Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?

Yes

(19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.

FACILITY NAME: North Kickapoo
ID # 0047290

BEGINNING: 1/1/2012
ENDING: 12/31/12

ATTACHED SCHEDULE I

SCHEDULE I - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Repairs / Maintenance	728
Mileage reimbursement for allowable travel	478
Fuel and miscellaneous supplies	2,402
	<u>3,608</u>

FACILITY NAME: North Kickapoo
ID # 0047290

BEGINNING: 1/1/2012
ENDING: 12/31/12

ATTACHED SCHEDULE II

SCHEDULE XX - (12)

Wage costs are allocated based on scheduled time.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	45,172	1,336	1,270	47,778	0	47,778	0	47,778
2. Food Purchase	0	31,232	0	31,232	0	31,232	0	31,232
3. Housekeeping	22,342	15,720	0	38,062	0	38,062	0	38,062
4. Laundry	0	731	0	731	0	731	0	731
5. Heat and Other Utilities	0	0	13,385	13,385	0	13,385	0	13,385
6. Maintenance	0	3,575	15,478	19,053	0	19,053	281	19,334
7. Other (specify)*	0	0	1,482	1,482	0	1,482	0	1,482
8. Total General Services	67,514	52,594	31,615	151,723	0	151,723	281	152,004
9. Medical Director	0	0	7,200	7,200	0	7,200	0	7,200
10. Nursing & Medical Records	167,996	10,018	5,081	183,095	0	183,095	0	183,095
10a. Therapy	0	0	1,478	1,478	0	1,478	0	1,478
11. Activities	21,560	8,394	0	29,954	0	29,954	0	29,954
12. Social Services	0	0	0	0	0	0	0	0
13. Nurse Aide Training	13,496	0	0	13,496	0	13,496	0	13,496
14. Program Transportation	0	0	8,627	8,627	0	8,627	-780	7,847
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	203,052	18,412	22,386	243,850	0	243,850	-780	243,070
17. Administrative	31,945	0	16,200	48,145	0	48,145	-930	47,215
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,465	8,465	0	8,465	382	8,847
20. Fees, Subscriptions & Promotion	0	0	1,949	1,949	0	1,949	297	2,246
21. Clerical & General Office	0	4,846	7,306	12,152	0	12,152	0	12,152
22. Employee Benefits & Payroll	0	0	53,340	53,340	0	53,340	1,450	54,790
23. Inservice Training & Education	0	0	441	441	0	441	0	441
24. Travel and Seminar	0	0	0	0	0	0	0	0
25. Other Admin. Staff Trans	0	0	3,608	3,608	0	3,608	0	3,608
26. Insurance-Prop.Liab.Malpractice	0	0	10,356	10,356	0	10,356	97	10,453
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	31,945	4,846	101,665	138,456	0	138,456	1,296	139,752
29. Total General Administrative	302,511	75,852	155,666	534,029	0	534,029	797	534,826
30. Depreciation	0	0	5,258	5,258	0	5,258	15,501	20,759
31. Amortization of Pre-Op. & Org.	0	0	35,000	35,000	0	35,000	-35,000	0
32. Interest	0	0	18,532	18,532	0	18,532	17,128	35,660
33. Real Estate	0	0	11,114	11,114	0	11,114	-210	10,904

34. Rent - Facility & Grounds	0	0	36,204	36,204	0	36,204	-36,204	0
35. Rent - Equipment & Vehicles	0	0	5,693	5,693	0	5,693	65	5,758
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	111,801	111,801	0	111,801	-38,720	73,081
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	158,265	158,265	0	158,265	0	158,265
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	43,394	43,394	0	43,394	0	43,394
43. Other (specify):*	0	0	1,000	1,000	0	1,000	-1,000	0
44. Total Special Cost Ce	0	0	202,659	202,659	0	202,659	-1,000	201,659
45. Grand Total	302,511	75,852	470,126	848,489	0	848,489	-38,923	809,566

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	30,722	30,722
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	137,027	137,027
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	19,478	19,478
9. Other (specify):	0	0
10. Total current assets	187,227	187,227
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	0	0
15. Leasehold Improvements, Historical Cost	500	500
16. Equipment, at Historical Cost	95,433	95,433
17. Accumulated Depreciation (book methods)	-74,889	-74,889
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	271,250	271,250
23. other (specify):	0	0
24. Total Long-Term Assets	292,294	292,294
25. Total Assets	479,521	479,521
CURRENT LIABILITIES		
26. Accounts Payable	44,553	44,553
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	14,421	14,421
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	858	858
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0

37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	59,832	59,832
LONG TERM LIABILITES		
39.Long-Term Notes Payable	103,309	103,309
40.Mortgage Payable	139,839	139,839
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	243,148	243,148
46.Total Liabilities	302,980	302,980
47.Total Equity	176,541	176,541
48.Total Liabilities and Equity	479,521	479,521

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	717,761
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	717,761
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	158,265
28. Other Revenue (specify):	2,064
Subtotal - Other Revenue	160,329
30. Total Revenue	878,090
31. General Services	151,723
32. Health Care	243,850
33. General Administration	138,456
34. Ownership	111,801

35. Special Cost Centers	159,265
35. Provider Participation Fee	43,394
37. Other	0
40. Total Expenses	848,489
41. Income Before Income Taxes	29,601
42. Income Taxes	0
43. Net Income or Loss for the Year	29,601