

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0047290

Facility Name: North Kickapoo

Address: 1903 N Kickapoo B511 Lincoln 62656
Number City Zip Code

County: Logan

Telephone Number: 217-428-7463 Fax # 217-422-6365

HFS ID Number:

Date of Initial License for Current Owners: 12/19/2006

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ 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: Jeremy Maupin Telephone Number: 217-422-6361
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/16 to 12/31/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Jeremy Maupin
(Title) President

Paid
Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT
(Print Name and Title) Larry Templin Partner
(Firm Name & Address) Templin Healthcare Accounting Services, LLP
P.O. Box 9, Dunlap, IL 61525
(Telephone) (630) 361-2868 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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo

0047290 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	5,509			5,509	13
14	TOTALS	5,509			5,509	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.07%

SEE ACCOUNTANTS' PREPARATION REPORT

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

G. 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 9/16/05 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/16 Ending: 12/31/16
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	36,325		1,012	37,337		37,337		37,337			1
2	Food Purchase		29,567		29,567		29,567		29,567			2
3	Housekeeping	21,163	14,498		35,661		35,661		35,661			3
4	Laundry											4
5	Heat and Other Utilities			14,312	14,312		14,312		14,312			5
6	Maintenance		3,232	10,052	13,284		13,284	308	13,592			6
7	Other (specify):* Waste Removal			2,625	2,625		2,625		2,625			7
8	TOTAL General Services	57,488	47,297	28,001	132,786		132,786	308	133,094			8
	B. Health Care and Programs											
9	Medical Director			7,500	7,500		7,500		7,500			9
10	Nursing and Medical Records	181,576	3,234	5,540	190,350		190,350		190,350			10
10a	Therapy			1,786	1,786		1,786		1,786			10a
11	Activities	16,651	10,328		26,979		26,979		26,979			11
12	Social Services											12
13	CNA Training	6,201			6,201		6,201		6,201			13
14	Program Transportation			7,280	7,280		7,280		7,280			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	204,428	13,562	22,106	240,096		240,096		240,096			16
	C. General Administration											
17	Administrative	24,285		30,300	54,585		54,585	(10,560)	44,025			17
18	Directors Fees											18
19	Professional Services			12,740	12,740		12,740	274	13,014			19
20	Dues, Fees, Subscriptions & Promotions			1,917	1,917		1,917	21	1,938			20
21	Clerical & General Office Expenses		4,525	5,458	9,983		9,983	2,077	12,060			21
22	Employee Benefits & Payroll Taxes			69,372	69,372		69,372	7,471	76,843			22
23	Inservice Training & Education			479	479		479		479			23
24	Travel and Seminar							549	549			24
25	Other Admin. Staff Transportation			1,985	1,985		1,985	13	1,998			25
26	Insurance-Prop.Liab.Malpractice			11,832	11,832		11,832		11,832			26
27	Other (specify):*											27
28	TOTAL General Administration	24,285	4,525	134,083	162,893		162,893	(155)	162,738			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	286,201	65,384	184,190	535,775		535,775	153	535,928			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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			24,776	24,776		24,776	5,737	30,513			30
31	Amortization of Pre-Op. & Org.			37,083	37,083		37,083	(37,083)				31
32	Interest			18,332	18,332		18,332	11,360	29,692			32
33	Real Estate Taxes			8,404	8,404		8,404	(65)	8,339			33
34	Rent-Facility & Grounds			36,204	36,204		36,204	(36,204)				34
35	Rent-Equipment & Vehicles			10,057	10,057		10,057	(28)	10,029			35
36	Other (specify):*											36
37	TOTAL Ownership			134,856	134,856		134,856	(56,283)	78,573			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			161,489	161,489		161,489		161,489			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			24,351	24,351		24,351		24,351			42
43	Other (specify):* Non-allowable costs											43
44	TOTAL Special Cost Centers			185,840	185,840		185,840		185,840			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	286,201	65,384	504,886	856,471		856,471	(56,130)	800,341			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 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	(6,479)	30		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	(65)	33		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(417)	19		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				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(37,083)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (44,044)		\$	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 Amount	2 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)	(12,086)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,086)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (56,130)		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 Yes	2 No	3 Amount	4 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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Amortization	\$ (37,083)	31	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(37,083)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/16 Ending: 12/31/16

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	308	0	0	0	0	0	0	0	0	0	308	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	308	0	0	0	0	0	0	0	0	0	308	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	(10,560)	0	0	0	0	0	0	0	0	0	(10,560)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(417)	691	0	0	0	0	0	0	0	0	0	274	19
20	Fees, Subscriptions & Promotions	0	21	0	0	0	0	0	0	0	0	0	21	20
21	Clerical & General Office Expenses	0	2,077	0	0	0	0	0	0	0	0	0	2,077	21
22	Employee Benefits & Payroll Taxes	0	7,471	0	0	0	0	0	0	0	0	0	7,471	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	549	0	0	0	0	0	0	0	0	0	549	24
25	Other Admin. Staff Transportation	0	13	0	0	0	0	0	0	0	0	0	13	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	(417)	262	0	0	0	0	0	0	0	0	0	(155)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(417)	570	0	0	0	0	0	0	0	0	0	153	29

Summary B

12/31/16

[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	J&J Maupin Homes Hickory Point Terrace	Forsyth	J&J Maupin Enterpris	Decatur, IL	Real Estate
		Joe Jac Spring Creek Terrace	Decatur	A Step Forward	Decatur, IL	Day Training & 3 CILAs

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)	
1	V	6	Maintenance	\$	J&J Maupin Enterprises	100.00%	\$ 308	\$ 308	1
2	V	17	Administrative	30,300	J&J Maupin Enterprises	100.00%	19,740	(10,560)	2
3	V	19	Professional Fees		J&J Maupin Enterprises	100.00%	691	691	3
4	V	20	Dues, Subscriptions, Licenses		J&J Maupin Enterprises	100.00%	21	21	4
5	V	21	Office Supplies & Expense		J&J Maupin Enterprises	100.00%	2,077	2,077	5
6	V	22	Employee Benefits		J&J Maupin Enterprises	100.00%	7,471	7,471	6
7	V	24	Travel & Seminar		J&J Maupin Enterprises	100.00%	549	549	7
8	V	25	Other Admin Staff Trans		J&J Maupin Enterprises	100.00%	13	13	8
9	V	30	Depreciation		J&J Maupin Enterprises	100.00%	12,216	12,216	9
10	V	32	Interest		J&J Maupin Enterprises	100.00%	11,360	11,360	10
11	V	35	Rent Exp	1,050	J&J Maupin Enterprises	100.00%	1,022	(28)	11
12	V	34	Rent Facility	36,204	J&J Maupin Enterprises	100.00%		(36,204)	12
13	V								13
14	Total			\$ 67,554			\$ 55,468	\$ * (12,086)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeremy Maupin	President	Administrative	100.00	74,660	15	25.00	Salary	\$ 19,740	L17, C 7	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	\$ 19,740		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/16 Ending: 12/31/16

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Maintenance	Revenue	4,330,603	4	\$ 1,472	\$	905,589	\$ 308	1
2	17	Administrative	Revenue	4,330,603	4	94,400	94,400	905,589	19,740	2
3	19	Professional Fees	Revenue	4,330,603	4	3,308		905,589	691	3
4	20	Dues, Subscriptions, Licenses	Revenue	4,330,603	4	100		905,589	21	4
5	21	Office Supplies & Expense	Revenue	4,330,603	4	9,931		905,589	2,077	5
6	22	Employee Benefits	Revenue	4,330,603	4	35,725		905,589	7,471	6
7	24	Travel & Seminar	Revenue	4,330,603	4	2,627		905,589	549	7
8	25	Other Admin Staff Trans	Revenue	4,330,603	4	61		905,589	13	8
9	30	Depreciation	Revenue	4,330,603	4	58,416		905,589	12,216	9
10	32	Interest	Revenue	4,330,603	4	54,325		905,589	11,360	10
11	35	Rent Exp	Revenue	4,330,603	4	4,888		905,589	1,022	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					\$ 265,253	\$ 94,400		\$ 55,468	25

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$	9/26/2015	4.2500	\$ 1,753	1	
2												2	
3												3	
4	RBS Citizens Bank		X	Auto Loan	\$394.92	11/14/14	22,124	10,208	11/14/19	2.1400	380	4	
5	Soy Capital		X	Auto Loan	\$440.52	8/1/16	25,371	22,865	7/1/2021	3.2400	256	5	
	Working Capital												
6	First Mid IL Bank & Trust		X	Line of Credit		9/26/09				6.0000	14,826	6	
7	Kim Robinson		X	Working Capital	\$1,130.44	9/16/05	170,000	69,067	8/16/2015	6.5000		7	
8	Heartland Bank & Trust		X	Line of Credit		11/10/16		26,000	11/10/17	4.5000	1,025	8	
9	TOTAL Facility Related				\$5,354.62		\$ 584,162	\$ 128,140			\$ 18,240	9	
	B. Non-Facility Related*												
10								Other Interest Expense			92	10	
11								Home Office allocation			11,360	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 11,452	14	
15	TOTALS (line 9+line14)						\$ 584,162	\$ 128,140			\$ 29,692	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.) SEE ACCOUNTANTS' PREPARATION REPORT

** 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 2015 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.)		2015	\$	8,339	2
3. Under or (over) accrual (line 2 minus line 1).			\$	8,339	3
4. Real Estate Tax accrual used for 2016 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.			\$		6
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.			\$	8,339	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011	10,904	8		
	2012	8,212	9		
	2013	8,386	10		
	2014	8,248	11		
	2015	8,339	12		
				13	FROM R. E. TAX STATEMENT FOR 2015 \$ 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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		15	33	33	216
10	Carpeting - 2 living rooms, bedrooms 4 & 5		2013		1,934		10	193	193	676
11	Flooring-Men's End Living Room		2015		1,300		10	130	130	195
12	New Kitchen Countertops		2015		1,508		10	151	151	226
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20	Financial Statement basis depreciation					24,776			(24,776)	
21										21
22										22
23	Allocated from J & J Maupin Enterprises							12,216	12,216	
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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo

0047290

Report Period Beginning:

1/1/16

Ending:

12/31/16

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)		\$ 5,242	\$ 24,776		\$ 12,723	\$ (12,053)	\$ 1,313	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$98,791	\$	\$9,879	\$9,879	5-10 yrs	\$70,458	71
72	Current Year Purchases	9,739		487	487	10	487	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$108,530	\$	\$10,366	\$10,366		\$70,945	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				5 yr	18,523	77
78	Program Transportation	2014 Ford Transit	2014	24,433		4,887	4,887	5 yr	10,181	78
79	Program Transportation	2013 Honda Van	2016	25,371		2,537	2,537	5 yr	2,537	79
80	TOTALS			\$70,827	\$	\$7,424	\$7,424		\$33,741	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)	\$184,599	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$24,776	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$30,513	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$5,737	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$105,999	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' PREPARATION REPORT

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?
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
- N/A

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: \$1,022
- Description: Office equipment
- (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	Administrative	2014 Honda Oddesey	501.55	6,019	17
18	Resident	2014 Dodge XST Van	426.98	2,988	18
19					19
20					20
21	TOTAL		\$928.53	\$9,007	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

☒

☐

☐

40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

80

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		6,201		6,201
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,201	\$	\$ 6,201
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,201			

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

\$

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	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
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Day Training	39(3)				161,489			161,489	13
14	TOTAL			\$		\$ 161,489	\$		\$ 161,489	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	\$ 27,670	\$ 27,670	1
2	Cash-Patient Deposits	2,100	2,100	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	72,919	72,919	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	170	170	7
8	Accounts Receivable (owners or related parties)	56,841	56,841	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 159,700	\$ 159,700	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	2,008	5,242	15
16	Equipment, at Historical Cost	182,591	179,357	16
17	Accumulated Depreciation (book methods)	(145,081)	(105,999)	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	126,580	126,580	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 166,098	\$ 205,180	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 325,798	\$ 364,880	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 21,458	\$ 21,458	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 21,458	\$ 21,458	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	128,140	128,140	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 128,140	\$ 128,140	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 149,598	\$ 149,598	46
47	TOTAL EQUITY(page 18, line 24)	\$ 176,200	\$ 215,282	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 325,798	\$ 364,880	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 268,588	1
2	Restatements (describe):		2
3	Prior Period Adjustment - Income / Day Training adjs	(116,261)	3
4	Prior Period Adjustment - Maint Exp reversal	392	4
5	Prior Period Adjustment - Reclassify Draws	1,095	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 153,814	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	49,118	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	(26,732)	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)	\$ 22,386	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)	\$ 176,200	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo

0047290

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	\$ 700,053	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 700,053	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	41,375	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)	\$ 41,375	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	<u>Workshop Revenue</u>	161,746	28
28a	<u>EIC \$1,535; Transportation charges \$880</u>	2,415	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 164,161	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 905,589	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	132,786	31
32	Health Care	240,096	32
33	General Administration	162,893	33
	B. Capital Expense		
34	Ownership	134,856	34
	C. Ancillary Expense		
35	Special Cost Centers	161,489	35
36	Provider Participation Fee	24,351	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 856,471	40
41	Income before Income Taxes (line 30 minus line 40)**	49,118	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 49,118	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 700,053	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)	\$ 700,053	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	639	719	19,891	27.66	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	644	644	6,201	9.63	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,667	1,699	16,651	9.80	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	2,970	3,146	36,325	11.55	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,704	2,016	21,163	10.50	18
19	Laundry					19
20	Administrator	520	520	24,285	46.70	20
21	Assistant Administrator					21
22	Other Administrative					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)	1,928	2,080	45,157	21.71	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	11,608	11,983	116,528	9.72	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,680	22,807	\$ 286,201 *	\$ 12.55	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	\$ 1,012	L1, C3	35
36	Medical Director	Monthly	7,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,200	L10, C3	38
39	Pharmacist Consultant	Monthly	168	L10, C3	39
40	Physical Therapy Consultant	Monthly	487	L10a, C3	40
41	Occupational Therapy Consultant	Monthly	487	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	812	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	1,172	L10, C3	46
47	Psychologist	Monthly	2,000	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 15,838		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

SEE ACCOUNTANTS' PREPARATION REPORT

* 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:

1/1/16

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Ending: 12/31/16

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kristi Nottelmann	Administrator	0	\$ 24,285
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 24,285

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	\$ 30,300
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 30,300

C. Professional Services

Vendor/Payee	Type	Amount
Kelly's Accounting	Accounting	\$ 1,059
Templin Healthcare Accounting	Accounting	1,050
McGuire, Yuhas, Huffman, Buckley,	Accounting	6,056
Bolen, Robinson, & Ellis, LLP	Legal Services	4,575
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 12,740

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 8,883
Unemployment Compensation Insurance	3,648
FICA Taxes	19,174
Employee Health Insurance	22,782
Employee Meals	14,885
Illinois Municipal Retirement Fund (IMRF)*	
Allocated from J & J Maupin Enterprises	7,471
TOTAL (agree to Schedule V, line 22, col.8)	\$ 76,843

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	1,031
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	1 35
Licenses and Fees	851
Allocated from J & J Maupin Enterprises	21
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,938

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Allocated from J & J Maupin Enterprises	549
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 549

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Facility Name & ID Number		North Kickapoo		STATE OF ILLINOIS	#	0047290	Report Period Beginning:	1/1/16	Ending:	12/31/16	Page 22	
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?			10								
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$		0		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.			\$		24,351						
	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.						
SEE ACCOUNTANTS' PREPARATION REPORT												
(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 benefit on Schedule V.			\$		14,885		Has any meal income been offset against related costs?		No		
						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?			79								
	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:											
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			Yes								
(19)	Has a schedule for the legal fees reported on the cost report been provided by the facility?			Yes		See page 39 of the instructions for details.						
	Attach invoices and a summary of services for all architect and appraisal fees											

North Kickapoo

Period Beginning	1/1/16
Period End	12/31/16

ATTACHED SCHEDULE

SCHEDULE XX - (12)

Wage costs are allocated based on scheduled time.