FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0047282

Facility Name: Hickory Point Terrace

Address: 260 E Lucille Ave (Number) Forsyth (City) 62535 (Zip Code)

County: Macon

Telephone Number: 217-875-2828 **Fax #** 217-422-6365

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			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 1/1/2012 to 12/31/12 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) (Date)
(Type or Print Name) Jeremy Maupin
(Title) President

Paid Preparer

(Signed) (Date)
(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**

Facility Name & ID Number Hickory Point Terrace # 0047282 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,714			5,714	13
14	TOTALS	5,714			5,714	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.58%

D. How many bed-hold days during this year were paid by the Department?
102 (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 [X] 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 [X]

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 [X] Date 9/16/05 NO [ ]

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/12 Fiscal Year: 12/31/12

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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	39,081	1,952	1,344	42,377		42,377		42,377			1
2	Food Purchase		28,893		28,893		28,893		28,893			2
3	Housekeeping	18,749	14,391		33,140		33,140		33,140			3
4	Laundry		1,390		1,390		1,390		1,390			4
5	Heat and Other Utilities			13,454	13,454		13,454		13,454			5
6	Maintenance		2,893	9,267	12,160		12,160	283	12,443			6
7	Other (specify):* Waste Removal			1,338	1,338		1,338		1,338			7
8	TOTAL General Services	57,830	49,519	25,403	132,752		132,752	283	133,035			8
	B. Health Care and Programs											
9	Medical Director			6,900	6,900		6,900		6,900			9
10	Nursing and Medical Records	171,697	7,491	5,510	184,698		184,698		184,698			10
10a	Therapy			1,967	1,967		1,967		1,967			10a
11	Activities	28,738	6,375		35,113		35,113		35,113			11
12	Social Services			380	380		380		380			12
13	CNA Training	9,484			9,484		9,484		9,484			13
14	Program Transportation			6,070	6,070		6,070	(600)	5,470			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	209,919	13,866	20,827	244,612		244,612	(600)	244,012			16
	C. General Administration											
17	Administrative	8,811		7,200	16,011		16,011	8,165	24,176			17
18	Directors Fees											18
19	Professional Services			8,589	8,589		8,589	384	8,973			19
20	Dues, Fees, Subscriptions & Promotions			2,450	2,450		2,450	298	2,748			20
21	Clerical & General Office Expenses		2,472	6,332	8,804		8,804		8,804			21
22	Employee Benefits & Payroll Taxes			52,588	52,588		52,588	1,459	54,047			22
23	Inservice Training & Education			492	492		492		492			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			3,389	3,389		3,389		3,389			25
26	Insurance-Prop.Liab.Malpractice			10,262	10,262		10,262	98	10,360			26
27	Other (specify):*											27
28	TOTAL General Administration	8,811	2,472	91,302	102,585		102,585	10,404	112,989			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	276,560	65,857	137,532	479,949		479,949	10,087	490,036			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hickory Point Terrace #0047282 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/12

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			5,190	5,190		5,190	15,598	20,788			30
31	Amortization of Pre-Op. & Org.			35,000	35,000		35,000	(35,000)				31
32	Interest			19,234	19,234		19,234	17,235	36,469			32
33	Real Estate Taxes			6,745	6,745		6,745	(50)	6,695			33
34	Rent-Facility & Grounds			97,404	97,404		97,404	(36,204)	61,200			34
35	Rent-Equipment & Vehicles			3,456	3,456		3,456	65	3,521			35
36	Other (specify):*											36
37	**TOTAL Ownership**			167,029	167,029		167,029	(38,356)	128,673			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			160,350	160,350		160,350		160,350			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,067	42,067		42,067		42,067			42
43	Other (specify):* Non-allowable Costs											43
44	**TOTAL Special Cost Centers**			202,417	202,417		202,417		202,417			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	276,560	65,857	506,978	849,395		849,395	(28,269)	821,126			45

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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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				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	(50)	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				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(35,600)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,650)		$	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)	7,381		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,381		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (28,269)		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

Hickory Point Terrace

ID# 0047282

Report Period Beginning: 1/1/2012

Ending: 12/31/12

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Transportation Income	$ (600)	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**	(35,600)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickory Point Terrace # 0047282 **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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	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	283	0	0	0	0	0	0	0	0	0	283	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	283	0	0	0	0	0	0	0	0	0	283	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	(600)	0	0	0	0	0	0	0	0	0	0	(600)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(600)	0	0	0	0	0	0	0	0	0	0	(600)	16
	C. General Administration													
17	Administrative	0	8,165	0	0	0	0	0	0	0	0	0	8,165	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	384	0	0	0	0	0	0	0	0	0	384	19
20	Fees, Subscriptions & Promotions	0	298	0	0	0	0	0	0	0	0	0	298	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	1,459	0	0	0	0	0	0	0	0	0	1,459	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	98	0	0	0	0	0	0	0	0	0	98	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	10,404	0	0	0	0	0	0	0	0	0	10,404	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(600)	10,687	0	0	0	0	0	0	0	0	0	10,087	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hickory Point Terrace # 0047282 **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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	15,598	0	0	0	0	0	0	0	0	0	15,598	30
31	Amortization of Pre-Op. & Org.	(35,000)	0	0	0	0	0	0	0	0	0	0	(35,000)	31
32	Interest	0	17,235	0	0	0	0	0	0	0	0	0	17,235	32
33	Real Estate Taxes	(50)	0	0	0	0	0	0	0	0	0	0	(50)	33
34	Rent-Facility & Grounds	0	(36,204)	0	0	0	0	0	0	0	0	0	(36,204)	34
35	Rent-Equipment & Vehicles	0	65	0	0	0	0	0	0	0	0	0	65	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(35,050)	(3,306)	0	0	0	0	0	0	0	0	0	(38,356)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(35,650)	7,381	0	0	0	0	0	0	0	0	0	(28,269)	45

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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	North Kickapoo	Lincoln	J&J Maupin Enterpris	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. [X] 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%	283	283	2
3	V	17	Administrative	7,200	J&J Maupin Enterprises	100.00%	15,365	8,165	3
4	V	19	Professional Fees		J&J Maupin Enterprises	100.00%	384	384	4
5	V	20	Dues, Subscriptions, Licenses		J&J Maupin Enterprises	100.00%	298	298	5
6	V	22	Employee Benefits		J&J Maupin Enterprises	100.00%	1,459	1,459	6
7	V	26	Insurance		J&J Maupin Enterprises	100.00%	98	98	7
8	V	30	Depreciation		J&J Maupin Enterprises	100.00%	15,598	15,598	8
9	V	32	Interest		J&J Maupin Enterprises	100.00%	17,235	17,235	9
10	V	35	Rent-Eqipment		J&J Maupin Enterprises	100.00%	65	65	10
11	V								11
12	V								12
13	V								13
14	Total			$ 43,404			$ 50,785	$ * 7,381	14

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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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	43,894	15	25.00	Salary	$ 13,039	L17, C 7	1
2	Jennifer Maupin	Controller	Other Admin	0.00	7,131	10	33.33	Salary	3,569	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	$ 16,608		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 Hickory Point Terrace # 0047282 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Revenue	3,257,229	4	$ 1,043	$	883,597	$ 283	1
2	17	Administrative	Revenue	3,257,229	4	56,641	56,641	883,597	15,365	2
3	19	Professional Fees	Revenue	3,257,229	4	1,418		883,597	384	3
4	20	Dues, Subscriptions, Licenses	Revenue	3,257,229	4	1,100		883,597	298	4
5	22	Employee Benefits	Revenue	3,257,229	4	5,378		883,597	1,459	5
6	26	Insurance	Revenue	3,257,229	4	362		883,597	98	6
7	30	Depreciation	Revenue	3,257,229	4	57,498		883,597	15,598	7
8	32	Interest	Revenue	3,257,229	4	63,534		883,597	17,235	8
9	35	Rent-Eqipment	Revenue	3,257,229	4	240		883,597	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		$ 50,785	25

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Mid IL Bank & Trust		X	Facility	$3,389.00	10/26/05	$ 366,667	$ 139,839	9/26/2015	4.2500	$ 6,782	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Mid IL Bank & Trust		X	Line of Credit		9/26/09		115,818	11/12/12	6.0000	4,983	6
7	Kim Robinson		X	Working Capital	$1,130.00	9/16/05	170,000	103,309	8/16/2015	6.5000	7,469	7
8												8
9	TOTAL Facility Related				$4,519.00		$ 536,667	$ 358,966			$ 19,234	9
	B. Non-Facility Related*											
10												10
11								Home Office allocation			17,235	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 17,235	14
15	TOTALS (line 9+line14)						$ 536,667	$ 358,966			$ 36,469	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.)**

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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	$ 6,695	2
3. Under or (over) accrual (line 2 minus line 1).		$ 6,695	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.		$ 6,695	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	6,398	8
	2008	6,576	9
	2009	6,605	10
	2010	6,719	11
	2011	6,695	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 Hickory Point Terrace COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0047282

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-07-23-101-005	Facility	$ 6,695.00	$ 6,695.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 6,695.00	$ 6,695.00

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.

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,030 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. [X] (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 [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Flooring			2009	6,216	504	15	504		1,125	9
10	Parking Lot			2010	9,769	793	15	793		1,445	10
11	Carpet			2012	652	53	10	53		53	11
12	Fencing			2012	1,459	118	10	118		118	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	Allocated from J & J Maupin Enterprises							15,598	15,598		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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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)		$ 18,096	$ 1,468		$ 17,066	$ 15,598	$ 2,741	70

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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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	$ 43,820	$ 3,556	$ 3,556	$	5-7 yr	$ 37,026	71
72	Current Year Purchases	2,057	166	166		5-10 yrs	166	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 45,877	$ 3,722	$ 3,722	$		$ 37,192	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	2003 Dodge Caravan	2005	$ 2,500	$	$	$	5 yr	$ 2,500	76
77										77
78										78
79										79
80	TOTALS			$ 2,500	$	$	$		$ 2,500	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)	$ 66,473	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 5,190	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 20,788	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,598	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 42,433	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Kim Robinson
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. [X] 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:	1998	16	09/16/05	$ 61,200	1		3
4	Additions							4
5								5
6								6
7	TOTAL		16		$ 61,200 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 9/17/12
    Ending 9/16/13

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] 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	Administrative	2011 Toyota Corolla	$ 314.22	$ 3,456	17
18					18
19					19
20					20
21	TOTAL		$ 314.22	$ 3,456	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] 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	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		9,484		9,484
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 9,484	$	$ 9,484
10	SUM OF line 9, col. 1 and 2 (e)	$ 9,484			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	8
2. From other facilities (f)	
TOTAL TRAINED	14

(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.

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Day Training	39 (3)				160,350			160,350	13
14	TOTAL			$		$ 160,350	$		$ 160,350	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.

STATE OF ILLINOIS

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 23,977	$ 23,977	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	147,757	147,757	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)	2,200	2,200	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 173,934	$ 173,934	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	18,692	18,096	15
16	Equipment, at Historical Cost	47,781	48,377	16
17	Accumulated Depreciation (book methods)	(42,433)	(42,433)	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 (spe **Goodwill**	244,916	244,916	22
23	Other(specify): **Amortizable Lease**	50,000	50,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 318,956	$ 318,956	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 492,890	$ 492,890	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 7,653	$ 7,653	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,794	12,794	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,358	1,358	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	82,661	82,661	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 104,466	$ 104,466	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	219,127	219,127	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)**	$ 358,966	$ 358,966	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 463,432	$ 463,432	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 29,458	$ 29,458	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 492,890	$ 492,890	48

***(See instructions.)**

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,139)	1	
2	Restatements (describe):		2	
3			3	
4	**Prior period adjustments**	1,395	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,744)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	34,202	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 34,202	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)**	$ 29,458	24	*

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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 700,347	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 700,347	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	18,882	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)**	$ 18,882	23
	D. Non-Operating Revenue		
24	Contributions	200	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 200	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Workshop Revenue	160,265	28
28a	EIC $3303, Transportation Income $600	3,903	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 164,168	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 883,597	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	132,752	31
32	Health Care	244,612	32
33	General Administration	102,585	33
	B. Capital Expense		
34	Ownership	167,029	34
	C. Ancillary Expense		
35	Special Cost Centers	160,350	35
36	Provider Participation Fee	42,067	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 849,395	40
41	**Income before Income Taxes (line 30 minus line 40)****	34,202	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 34,202	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 700,347	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)	$ 700,347	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.**

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	693	693	17,764	25.63	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	1,107	1,107	9,484	8.57	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,767	1,943	22,450	11.55	9
10	Activity Assistants	707	707	6,288	8.89	10
11	Social Service Workers					11
12	Dietician	3,716	3,928	39,081	9.95	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,038	2,158	18,749	8.69	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	421	421	8,811	20.93	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)	2,517	2,565	53,966	21.04	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	9,805	10,096	99,967	9.90	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,771	23,618	$ 276,560 *	$ 11.71	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 1,344	L1, C3	35
36	Medical Director	Monthly	6,900	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	600	L10, C3	38
39	Pharmacist Consultant	Monthly	599	L10, C3	39
40	Physical Therapy Consultant	Monthly	894	L10a, C3	40
41	Occupational Therapy Consultant	Monthly	520	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	553	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	380	L12, C3	45
46	Other(specify) Dental	Monthly	1,293	L10, C3	46
47	Psychologist	Monthly	1,490	L10, C3	47
48	Podiatry	Monthly	1,528	L10, C3	48
49	TOTAL (lines 35 - 48)		$ 16,101		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Maupin	Administrator	100	$
Jennifer Maupin	Other Admin	0	1,262
Kristi Nottelmann	Other Admin	0	7,549
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 8,811

B. Administrative - Other

Description	Amount
Management Fees - Eliminated in Col. 7	$ 7,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 7,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Martin, Hood, Friese & Associates, I	Accounting	$ 3,050
Kelly's Accounting	Accounting	5,168
Quickbooks	Payroll Service	371
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 8,589

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,759
Unemployment Compensation Insurance	3,067
FICA Taxes	21,129
Employee Health Insurance	1,609
Employee Meals	14,024
Illinois Municipal Retirement Fund (IMRF)*	
Allocated from J & J Maupin Enterprises	1,459
TOTAL (agree to Schedule V, line 22, col.8)	$ 54,047

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,273
Health Care Worker Background Check	907
(Indicate # of checks performed 70)	
Patient Background Checks	
Licenses and Fees	270
Allocated from J & J Maupin Enterprises	298
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,748

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
N/A	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2012 Ending: 12/31/12

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	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Hickory Point Terrace **#** 0047282 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/12

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **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? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **992** 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. $ **42,067**
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. $ **14,024** 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 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: Hickory Point Terrace **BEGINNING:** 1/1/2012
ID # 0047282 **ENDING:** 12/31/12

ATTACHED SCHEDULE I

SCHEDULE I - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Repairs / Maintenance	**66**
Mileage reimbursement for allowable travel	**321**
Fuel and miscellaneous supplies	**3,002**
	3,389

FACILITY NAME: **Hickory Point Terrace** **BEGINNING:** **1/1/2012**
ID # **0047282** **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	Adjustments	Adjusted Total
1. Dietary	39,081	1,952	1,344	42,377	0	42,377	0	42,377
2. Food Purchase	0	28,893	0	28,893	0	28,893	0	28,893
3. Housekeeping	18,749	14,391	0	33,140	0	33,140	0	33,140
4. Laundry	0	1,390	0	1,390	0	1,390	0	1,390
5. Heat and Other Utilities	0	0	13,454	13,454	0	13,454	0	13,454
6. Maintenance	0	2,893	9,267	12,160	0	12,160	283	12,443
7. Other (specify)*	0	0	1,338	1,338	0	1,338	0	1,338
8. Total General Services	57,830	49,519	25,403	132,752	0	132,752	283	133,035
9. Medical Director	0	0	6,900	6,900	0	6,900	0	6,900
10. Nursing & Medical Records	171,697	7,491	5,510	184,698	0	184,698	0	184,698
10a. Therapy	0	0	1,967	1,967	0	1,967	0	1,967
11. Activities	28,738	6,375	0	35,113	0	35,113	0	35,113
12. Social Services	0	0	380	380	0	380	0	380
13. Nurse Aide Training	9,484	0	0	9,484	0	9,484	0	9,484
14. Program Transportation	0	0	6,070	6,070	0	6,070	-600	5,470
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	209,919	13,866	20,827	244,612	0	244,612	-600	244,012
17. Administrative	8,811	0	7,200	16,011	0	16,011	8,165	24,176
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,589	8,589	0	8,589	384	8,973
20. Fees, Subscriptions & Promotion	0	0	2,450	2,450	0	2,450	298	2,748
21. Clerical & General Office	0	2,472	6,332	8,804	0	8,804	0	8,804
22. Employee Benefits & Payroll	0	0	52,588	52,588	0	52,588	1,459	54,047
23. Inservice Training & Education	0	0	492	492	0	492	0	492
24. Travel and Seminar	0	0	0	0	0	0	0	0
25. Other Admin. Staff Trans	0	0	3,389	3,389	0	3,389	0	3,389
26. Insurance-Prop.Liab.Malpractice	0	0	10,262	10,262	0	10,262	98	10,360
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	8,811	2,472	91,302	102,585	0	102,585	10,404	112,989
29. Total General Administrative	276,560	65,857	137,532	479,949	0	479,949	10,087	490,036
30. Depreciation	0	0	5,190	5,190	0	5,190	15,598	20,788
31. Amortization of Pre-Op. & Org.	0	0	35,000	35,000	0	35,000	-35,000	0
32. Interest	0	0	19,234	19,234	0	19,234	17,235	36,469
33. Real Estate	0	0	6,745	6,745	0	6,745	-50	6,695

34. Rent - Facility & Grounds		0	0	97,404	97,404	0	97,404	-36,204	61,200
35. Rent - Equipment & Vehicles		0	0	3,456	3,456	0	3,456	65	3,521
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	167,029	167,029	0	167,029	-38,356	128,673
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	0	160,350	160,350	0	160,350	0	160,350
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	42,067	42,067	0	42,067	0	42,067
43. Other (specify):*		0	0	0	0	0	0	0	0
44. Total Special Cost Ce		0	0	202,417	202,417	0	202,417	0	202,417
45. Grand Total		276,560	65,857	506,978	849,395	0	849,395	-28,269	821,126

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	23,977	23,977
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	147,757	147,757
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	2,200	2,200
9. Other (specify):	0	0
10. Total current assets	173,934	173,934
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	18,692	18,096
16. Equipment, at Historical Cost	47,781	48,377
17. Accumulated Depreciation (book methods)	-42,433	-42,433
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):	244,916	244,916
23. other (specify):	50,000	50,000
24. Total Long-Term Assets	318,956	318,956
25. Total Assets	492,890	492,890
CURRENT LIABILITIES		
26. Accounts Payable	7,653	7,653
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	12,794	12,794
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	1,358	1,358
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	82,661	82,661

37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	104,466	104,466
LONG TERM LIABILITES		
39.Long-Term Notes Payable	219,127	219,127
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	358,966	358,966
46.Total Liabilities	463,432	463,432
47.Total Equity	29,458	29,458
48.Total Liabilities and Equity	492,890	492,890

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	700,347
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	700,347
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	18,882
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	18,882
24. Contributions	200
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	200
27. Other Revenue (specify):	160,265
28. Other Revenue (specify):	3,903
Subtotal - Other Revenue	164,168
30. Total Revenue	883,597
31. General Services	132,752
32. Health Care	244,612
33. General Administration	106,041
34. Ownership	163,573

35.	Special Cost Centers	160,350
35.	Provider Participation Fee	42,067
37.	Other	0
40.	Total Expenses	849,395
41.	Income Before Income Taxes	34,202
42.	Income Taxes	0
43.	Net Income or Loss for the Year	34,202