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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0047290

Facility Name: North Kickapoo

Address: 1903 N Kickapoo St (Number) | Lincoln (City) | 62656 (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	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 1/1/2013 to 12/31/13 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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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 N/A

	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	5,840	6
7	16	TOTALS	16	5,840	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	5,766			5,766	13
14	TOTALS	5,766			5,766	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.73%

D. How many bed-hold days during this year were paid by the Department?
29 (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: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	45,575	838	1,060	47,473		47,473		47,473			1
2	Food Purchase		29,430		29,430		29,430		29,430			2
3	Housekeeping	18,646	13,613		32,259		32,259		32,259			3
4	Laundry		798		798		798		798			4
5	Heat and Other Utilities			12,025	12,025		12,025		12,025			5
6	Maintenance		4,725	16,818	21,543		21,543	217	21,760			6
7	Other (specify):* **Waste Removal**			1,222	1,222		1,222		1,222			7
8	**TOTAL General Services**	64,221	49,404	31,125	144,750		144,750	217	144,967			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	173,987	10,880	9,670	194,537		194,537		194,537			10
10a	Therapy			1,857	1,857		1,857		1,857			10a
11	Activities	18,289	8,098		26,387		26,387		26,387			11
12	Social Services											12
13	CNA Training	7,040			7,040		7,040		7,040			13
14	Program Transportation			13,408	13,408		13,408	(5,561)	7,847			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	199,316	18,978	32,135	250,429		250,429	(5,561)	244,868			16
	C. General Administration											
17	Administrative	24,470		23,400	47,870		47,870	(3,946)	43,924			17
18	Directors Fees											18
19	Professional Services			7,798	7,798		7,798	324	8,122			19
20	Dues, Fees, Subscriptions & Promotions			4,150	4,150		4,150	30	4,180			20
21	Clerical & General Office Expenses		3,964	5,707	9,671		9,671	33	9,704			21
22	Employee Benefits & Payroll Taxes			52,024	52,024		52,024	5,675	57,699			22
23	Inservice Training & Education			104	104		104		104			23
24	Travel and Seminar			580	580		580		580			24
25	Other Admin. Staff Transportation			4,343	4,343		4,343	381	4,724			25
26	Insurance-Prop.Liab.Malpractice			10,593	10,593		10,593	91	10,684			26
27	Other (specify):*											27
28	**TOTAL General Administration**	24,470	3,964	108,699	137,133		137,133	2,588	139,721			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	288,007	72,346	171,959	532,312		532,312	(2,756)	529,556			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 North Kickapoo #0047290 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/13

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			1,800	1,800		1,800	13,863	15,663			30
31	Amortization of Pre-Op. & Org.			35,000	35,000		35,000	(35,000)				31
32	Interest			18,311	18,311		18,311	13,953	32,264			32
33	Real Estate Taxes			8,274	8,274		8,274	(62)	8,212			33
34	Rent-Facility & Grounds			36,204	36,204		36,204	(36,204)				34
35	Rent-Equipment & Vehicles			6,832	6,832		6,832	77	6,909			35
36	Other (specify):*											36
37	**TOTAL Ownership**			106,421	106,421		106,421	(43,373)	63,048			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			202,638	202,638		202,638		202,638			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,447	43,447		43,447		43,447			42
43	Other (specify):* Non-allowable Costs			834	834		834	(834)				43
44	**TOTAL Special Cost Centers**			246,919	246,919		246,919	(834)	246,085			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	288,007	72,346	525,299	885,652		885,652	(46,963)	838,689			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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	(62)	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	(834)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(40,180)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (41,076)		$	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)	(5,887)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (5,887)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (46,963)		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

STATE OF ILLINOIS **Page 5A**

North Kickapoo

ID# 0047290

Report Period Beginning: 1/1/2013

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Transportation Income	$ (840)	14	1
2	Disallow Amortization	(35,000)	31	2
3	Disallow non-facility vehicle gas expense	(5,062)	14	3
4	Additional Vehicle gas expense	341	14	4
5	Additional Vehicle gas expense	381	25	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**	(40,180)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Kickapoo **#** 0047290 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/13

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	217	0	0	0	0	0	0	0	0	0	217	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	217	0	0	0	0	0	0	0	0	0	217	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	(5,561)	0	0	0	0	0	0	0	0	0	0	(5,561)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(5,561)	0	0	0	0	0	0	0	0	0	0	(5,561)	16
	C. General Administration													
17	Administrative	0	(3,946)	0	0	0	0	0	0	0	0	0	(3,946)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	324	0	0	0	0	0	0	0	0	0	324	19
20	Fees, Subscriptions & Promotions	0	30	0	0	0	0	0	0	0	0	0	30	20
21	Clerical & General Office Expenses	0	33	0	0	0	0	0	0	0	0	0	33	21
22	Employee Benefits & Payroll Taxes	0	5,675	0	0	0	0	0	0	0	0	0	5,675	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	381	0	0	0	0	0	0	0	0	0	0	381	25
26	Insurance-Prop.Liab.Malpractice	0	91	0	0	0	0	0	0	0	0	0	91	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	381	2,207	0	0	0	0	0	0	0	0	0	2,588	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,180)	2,424	0	0	0	0	0	0	0	0	0	(2,756)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Kickapoo # 0047290 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/13

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	13,863	0	0	0	0	0	0	0	0	0	13,863	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	13,953	0	0	0	0	0	0	0	0	0	13,953	32
33	Real Estate Taxes	(62)	0	0	0	0	0	0	0	0	0	0	(62)	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	77	0	0	0	0	0	0	0	0	0	77	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(35,062)	(8,311)	0	0	0	0	0	0	0	0	0	(43,373)	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):*	(834)	0	0	0	0	0	0	0	0	0	0	(834)	43
44	**TOTAL Special Cost Centers**	(834)	0	0	0	0	0	0	0	0	0	0	(834)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(41,076)	(5,887)	0	0	0	0	0	0	0	0	0	(46,963)	45

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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
		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	6	Maintenance	$	J&J Maupin Enterprises	100.00%	$ 217	$ 217	1
2	V	17	Administrative	23,400	J&J Maupin Enterprises	100.00%	19,454	(3,946)	2
3	V	19	Professional Fees		J&J Maupin Enterprises	100.00%	324	324	3
4	V	20	Dues, Subscriptions, Licenses		J&J Maupin Enterprises	100.00%	30	30	4
5	V	21	Clerical & General Admin		J&J Maupin Enterprises	100.00%	33	33	5
6	V	22	Employee Benefits		J&J Maupin Enterprises	100.00%	5,675	5,675	6
7	V	26	Insurance		J&J Maupin Enterprises	100.00%	91	91	7
8	V	30	Depreciation		J&J Maupin Enterprises	100.00%	13,863	13,863	8
9	V	32	Interest		J&J Maupin Enterprises	100.00%	13,953	13,953	9
10	V	35	Rent-Eqipment		J&J Maupin Enterprises	100.00%	77	77	10
11	V	34	Rent	36,204	J&J Maupin Enterprises	100.00%		(36,204)	11
12	V								12
13	V								13
14	Total			$ 59,604			$ 53,717	$ * (5,887)	14

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

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	53,295	15	25.00	Salary	$ 16,450	L17, C 7	1
2	Jeremy Maupin	President	Administrative	100.00	12,866	15	25.00	Pension	3,971	L22, C7	2
3	Jennifer Maupin	Controller	Other Admin	0.00	9,734	10	33.33	Salary	3,004	L17, C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,425		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	3,906,682	4	$ 917	$	921,411	$ 217	1
2	17	Administrative	Revenue	3,906,682	4	82,481	82,481	921,411	19,454	2
3	19	Professional Fees	Revenue	3,906,682	4	1,372		921,411	324	3
4	20	Dues, Subscriptions, Licenses	Revenue	3,906,682	4	127		921,411	30	4
5	21	Clerical & General Admin	Revenue	3,906,682	4	143		921,411	33	5
6	22	Employee Benefits	Revenue	3,906,682	4	24,059		921,411	5,675	6
7	26	Insurance	Revenue	3,906,682	4	388		921,411	91	7
8	30	Depreciation	Revenue	3,906,682	4	58,776		921,411	13,863	8
9	32	Interest	Revenue	3,906,682	4	59,162		921,411	13,953	9
10	35	Rent-Eqipment	Revenue	3,906,682	4	325		921,411	77	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					$ 227,750	$ 82,481		$ 53,717	25

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	$3,388.74	10/26/05	$ 366,667	$ 104,412	9/26/2015	4.2500	$ 5,238	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Mid IL Bank & Trust		X	Line of Credit		9/26/09			11/12/12	6.0000	6,045	6
7	Kim Robinson		X	Working Capital	$1,130.44	9/16/05	170,000	96,772	8/16/2015	6.5000	7,028	7
8												8
9	TOTAL Facility Related				$4,519.18		$ 536,667	$ 201,184			$ 18,311	9
	B. Non-Facility Related*											
10												10
11								Home Office allocation			13,953	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 13,953	14
15	TOTALS (line 9+line14)						$ 536,667	$ 201,184			$ 32,264	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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)	2012	$ 8,212	2
3. Under or (over) accrual (line 2 minus line 1).		$ 8,212	3
4. Real Estate Tax accrual used for 2013 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.		$ 8,212	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	10,064	8
	2009	10,738	9
	2010	10,626	10
	2011	10,904	11
	2012	8,212	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Kickapoo COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0047290

CONTACT PERSON REGARDING THIS REPORT Jeremy Maupin

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-029-015-50	Facility	$ 8,211.96	$ 8,211.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 8,211.96	$ 8,211.96

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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 [X] (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? [X] (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 [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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	Parking Lot			2009	500	33	15	33		117	9
10	Carpeting - 2 living rooms, bedrooms 4 & 5			2013	1,934	97	10	97		97	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	Allocated from J & J Maupin Enterprises							13,863	13,863		23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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)		$ 2,434	$ 130		$ 13,993	$ 13,863	$ 214	70

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

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	$ 74,410	$ 1,622	$ 1,622	$	5-7 yrs	$ 55,404	71
72	Current Year Purchases	963	48	48		10 yrs	48	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 75,373	$ 1,670	$ 1,670	$		$ 55,452	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										78
79										79
80	TOTALS			$ 21,023	$	$	$		$ 21,023	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)	$ 98,830	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,800	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 15,663	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13,863	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 76,689	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			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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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 .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 77 Description: Allocated from J & J Enterprises
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident	2011 Toyota Sienna	$ 569.34	$ 6,832	17
18					18
19					19
20					20
21	TOTAL		$ 569.34	$ 6,832	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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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)		7,040		7,040
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 7,040	$	$ 7,040
10	SUM OF line 9, col. 1 and 2 (e)	$ 7,040			

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	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	13

(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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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)				202,638			202,638	13
14	TOTAL			$		$ 202,638	$		$ 202,638	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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13 (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	$ 24,224	$ 24,224	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	83,305	83,305	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)	27,978	27,978	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 135,507	$ 135,507	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	500	2,434	15
16	Equipment, at Historical Cost	98,330	96,396	16
17	Accumulated Depreciation (book methods)	(76,689)	(76,689)	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**	236,250	236,250	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 258,391	$ 258,391	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 393,898	$ 393,898	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 4,753	$ 4,753	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,804	11,804	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	858	858	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 17,415	$ 17,415	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	96,772	96,772	39
40	Mortgage Payable	104,412	104,412	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)**	$ 201,184	$ 201,184	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 218,599	$ 218,599	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 175,299	$ 175,299	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 393,898	$ 393,898	48

*(See instructions.)

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 176,541	1
2	Restatements (describe):		2
3	**Rounding**	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 176,540	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	35,759	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	(37,000)	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)**	$ (1,241)	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)**	$ 175,299	24 *

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

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	$ 714,184	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 714,184	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Workshop Revenue	202,598	28
28a	EIC $3789, Transportation Income $840	4,629	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 207,227	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 921,411	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	144,750	31
32	Health Care	250,429	32
33	General Administration	137,133	33
	B. Capital Expense		
34	Ownership	106,421	34
	C. Ancillary Expense		
35	Special Cost Centers	203,472	35
36	Provider Participation Fee	43,447	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 885,652	40
41	**Income before Income Taxes (line 30 minus line 40)****	35,759	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 35,759	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 714,184	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)	$ 714,184	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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	680	651	17,163	26.36	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	780	780	7,040	9.03	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,424	1,439	14,372	9.99	9
10	Activity Assistants	404	404	3,917	9.70	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,688	3,973	45,575	11.47	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,500	1,632	18,646	11.43	18
19	Laundry					19
20	Administrator	595	611	24,470	40.05	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)	1,996	2,080	40,357	19.40	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	11,483	11,781	116,467	9.89	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	22,550	23,351	$ 288,007 *	$ 12.33	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	$ 1,060	L1, C3	35
36	Medical Director	Monthly	7,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	5,133	L10, C3	38
39	Pharmacist Consultant	Monthly	662	L10, C3	39
40	Physical Therapy Consultant	Monthly	325	L10a, C3	40
41	Occupational Therapy Consultant	Monthly	487	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	1,045	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental	Monthly	2,360	L10, C3	46
47	Psychologist	Monthly	1,315	L10, C3	47
48	Podiatry	Monthly	200	L10, C3	48
49	TOTAL (lines 35 - 48)		$ 19,787		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 North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Maupin	Administrator	100	$ 0
Kristi Nottelmann	Other Admin	0	24,470
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 24,470

B. Administrative - Other

Description	Amount
Management Fees - Eliminated in Col. 7	$ 23,400
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 23,400

C. Professional Services

Vendor/Payee	Type	Amount
Kelly's Accounting	Accounting	$ 4,610
Templin Healthcare Accounting	Accounting	1,000
Quickbooks	Payroll Service	77
Duane Morris	Legal Services	1,901
Bolen, Robinson, & Ellis, LLP	Legal Services	180
Legal Zoom	Legal Documents	30
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 7,798

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 8,830
Unemployment Compensation Insurance	3,701
FICA Taxes	18,017
Employee Health Insurance	7,321
Employee Meals	14,155
Illinois Municipal Retirement Fund (IMRF)*	
Allocated from J & J Maupin Enterprises	5,675
TOTAL (agree to Schedule V, line 22, col.8)	$ 57,699

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	1,077
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Licenses and Fees	590
Clinical Software licensing fees	2,483
Allocated from J & J Maupin Enterprises	30
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,180

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	580
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 580

**See instructions.

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2013 Ending: 12/31/13

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? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,364** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **43,447**
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. $ **14,155** 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: North Kickapoo
ID # 0047290

BEGINNING: 1/1/2013
ENDING: 12/31/13

ATTACHED SCHEDULE I

SCHEDULE V - LINE 24 - TRAVEL AND SEMINAR

Name	Job Title	Description	Travel Expenses					Seminar Exp	Total Travel & Seminar
			Travel	Meals	Lodging	Out of St.	Total		
Kristi Nottlemann	Administrator	ARC Conference, Lisle, IL						290.00	290.00
Jeremy Maupin	Owner/Administrator	ARC Conference, Lisle, IL					-	290.00	290.00
							-		-
									-
			$ -	$ -	$ -	$ -	$ -	$ 580.00	$ 580.00

FACILITY NAME:	**North Kickapoo**	**BEGINNING:**	**1/1/2013**
ID #	**0047290**	**ENDING:**	**12/31/13**

ATTACHED SCHEDULE II

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Repairs / Maintenance	**-**
Mileage reimbursement for allowable travel	**717**
Fuel and miscellaneous supplies	**4,007**
	4,724

FACILITY NAME: North Kickapoo **BEGINNING:** 1/1/2013
ID # 0047290 **ENDING:** 12/31/13

ATTACHED SCHEDULE III

SCHEDULE XX - (12)

Wage costs are allocated based on scheduled time.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	45,575	838	1,060	47,473	0	47,473	0	47,473
2. Food Purchase	0	29,430	0	29,430	0	29,430	0	29,430
3. Housekeeping	18,646	13,613	0	32,259	0	32,259	0	32,259
4. Laundry	0	798	0	798	0	798	0	798
5. Heat and Other Utilities	0	0	12,025	12,025	0	12,025	0	12,025
6. Maintenance	0	4,725	16,818	21,543	0	21,543	217	21,760
7. Other (specify)*	0	0	1,222	1,222	0	1,222	0	1,222
8. Total General Services	64,221	49,404	31,125	144,750	0	144,750	217	144,967
9. Medical Director	0	0	7,200	7,200	0	7,200	0	7,200
10. Nursing & Medical Records	173,987	10,880	9,670	194,537	0	194,537	0	194,537
10a. Therapy	0	0	1,857	1,857	0	1,857	0	1,857
11. Activities	18,289	8,098	0	26,387	0	26,387	0	26,387
12. Social Services	0	0	0	0	0	0	0	0
13. Nurse Aide Training	7,040	0	0	7,040	0	7,040	0	7,040
14. Program Transportation	0	0	13,408	13,408	0	13,408	-5,561	7,847
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	199,316	18,978	32,135	250,429	0	250,429	-5,561	244,868
17. Administrative	24,470	0	23,400	47,870	0	47,870	-3,946	43,924
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	7,798	7,798	0	7,798	324	8,122
20. Fees, Subscriptions & Promotion	0	0	4,150	4,150	0	4,150	30	4,180
21. Clerical & General Office	0	3,964	5,707	9,671	0	9,671	33	9,704
22. Employee Benefits & Payroll	0	0	52,024	52,024	0	52,024	5,675	57,699
23. Inservice Training & Education	0	0	104	104	0	104	0	104
24. Travel and Seminar	0	0	580	580	0	580	0	580
25. Other Admin. Staff Trans	0	0	4,343	4,343	0	4,343	381	4,724
26. Insurance-Prop.Liab.Malpractice	0	0	10,593	10,593	0	10,593	91	10,684
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	24,470	3,964	108,699	137,133	0	137,133	2,588	139,721
29. Total General Administrative	288,007	72,346	171,959	532,312	0	532,312	-2,756	529,556
30. Depreciation	0	0	1,800	1,800	0	1,800	13,863	15,663
31. Amortization of Pre-Op. & Org.	0	0	35,000	35,000	0	35,000	-35,000	0
32. Interest	0	0	18,311	18,311	0	18,311	13,953	32,264
33. Real Estate	0	0	8,274	8,274	0	8,274	-62	8,212

34. Rent - Facility & Grounds		0	0	36,204	36,204	0	36,204	-36,204	0
35. Rent - Equipment & Vehicles		0	0	6,832	6,832	0	6,832	77	6,909
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	106,421	106,421	0	106,421	-43,373	63,048
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	0	202,638	202,638	0	202,638	0	202,638
40. Barber and Beauty Shop		0	0	0	0	0	0	0	0
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	43,447	43,447	0	43,447	0	43,447
43. Other (specify):*		0	0	834	834	0	834	-834	0
44. Total Special Cost Ce		0	0	246,919	246,919	0	246,919	-834	246,085
45. Grand Total		288,007	72,346	525,299	885,652	0	885,652	-46,963	838,689

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	24,224	24,224
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	83,305	83,305
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	27,978	27,978
9. Other (specify):	0	0
10. Total current assets	135,507	135,507
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	0	0
15. Leasehold Improvements, Historical Cost	500	2,434
16. Equipment, at Historical Cost	98,330	96,396
17. Accumulated Depreciation (book methods)	-76,689	-76,689
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):	236,250	236,250
23. other (specify):	0	0
24. Total Long-Term Assets	258,391	258,391
25. Total Assets	393,898	393,898
CURRENT LIABILITIES		
26. Accounts Payable	4,753	4,753
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	11,804	11,804
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	858	858
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0

37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	17,415	17,415
LONG TERM LIABILITES		
39.Long-Term Notes Payable	96,772	96,772
40.Mortgage Payable	104,412	104,412
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	201,184	201,184
46.Total Liabilities	218,599	218,599
47.Total Equity	175,299	175,299
48.Total Liabilities and Equity	393,898	393,898

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	714,184
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	714,184
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	202,598
28. Other Revenue (specify):	4,629
Subtotal - Other Revenue	207,227
30. Total Revenue	921,411
31. General Services	144,750
32. Health Care	250,429
33. General Administration	137,133
34. Ownership	106,421

35.	Special Cost Centers	203,472
35.	Provider Participation Fee	43,447
37.	Other	0
40.	Total Expenses	885,652
41.	Income Before Income Taxes	35,759
42.	Income Taxes	0
43.	Net Income or Loss for the Year	35,759