

		FOR BHF USE					

LL1

**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH License ID Number:** 0047290

**Facility Name:** North Kickapoo

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

**County:** Logan

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

**HFS ID Number:** \_\_\_\_\_

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

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> 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 1/1/2014 to 12/31/2014 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____
	(Type or Print Name) <u>Jeremy Maupin</u> (Date) _____
<b>Paid Preparer</b>	(Title) <u>President</u>
	(Signed) _____
	(Print Name and Title) <u>Larry Templin</u> <u>Partner</u>
	(Firm Name & Address) <u>Templin Healthcare Accounting Services, LLP</u> <u>P.O. Box 9, Dunlap, IL 61525</u>
	(Telephone) <u>(630) 361-2868</u> Fax # ( ) _____
MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

Facility Name & ID Number North Kickapoo

# 0047290 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,545			5,545	13
14	TOTALS	5,545			5,545	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.95%

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

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

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

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

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 09/16/05

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

YES  Date 9/16/05 NO

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

YES  NO  If YES, enter number of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	43,402		1,296	44,698		44,698	44,698		1	
2	Food Purchase		35,468		35,468		35,468	35,468		2	
3	Housekeeping	21,403	14,984		36,387		36,387	36,387		3	
4	Laundry									4	
5	Heat and Other Utilities			13,324	13,324		13,324	13,324		5	
6	Maintenance		7,287	14,814	22,101		22,101	22,368	267	6	
7	Other (specify):* <b>Waste Removal</b>			1,341	1,341		1,341	1,341		7	
8	<b>TOTAL General Services</b>	64,805	57,739	30,775	153,319		153,319	153,586	267	8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200	7,200		9	
10	Nursing and Medical Records	175,086	7,856	10,858	193,800		193,800	193,800		10	
10a	Therapy			1,478	1,478		1,478	1,478		10a	
11	Activities	20,898	10,399		31,297		31,297	31,297		11	
12	Social Services									12	
13	CNA Training	6,629			6,629		6,629	6,629		13	
14	Program Transportation			5,295	5,295		5,295	5,295		14	
15	Other (specify):*									15	
16	<b>TOTAL Health Care and Programs</b>	202,613	18,255	24,831	245,699		245,699	245,699		16	
	<b>C. General Administration</b>										
17	Administrative	24,496		29,400	53,896		53,896	46,049	(7,847)	17	
18	Directors Fees									18	
19	Professional Services			7,405	7,405		7,405	7,762	357	19	
20	Dues, Fees, Subscriptions & Promotions			240	240		240	267	27	20	
21	Clerical & General Office Expenses		3,214	4,751	7,965		7,965	8,078	113	21	
22	Employee Benefits & Payroll Taxes			55,655	55,655		55,655	58,350	2,695	22	
23	Inservice Training & Education			2,016	2,016		2,016	2,016		23	
24	Travel and Seminar									24	
25	Other Admin. Staff Transportation			4,195	4,195		4,195	4,195		25	
26	Insurance-Prop.Liab.Malpractice			12,398	12,398		12,398	12,398		26	
27	Other (specify):*									27	
28	<b>TOTAL General Administration</b>	24,496	3,214	116,060	143,770		143,770	139,115	(4,655)	28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	291,914	79,208	171,666	542,788		542,788	538,400	(4,388)	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:

1/1/2014

Ending:

12/31/2014

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			2,304	2,304		2,304	12,752	15,056			30
31	Amortization of Pre-Op. & Org.			35,000	35,000		35,000	(35,000)				31
32	Interest			13,873	13,873		13,873	12,242	26,115			32
33	Real Estate Taxes			8,386	8,386		8,386		8,386			33
34	Rent-Facility & Grounds			36,204	36,204		36,204	(36,204)				34
35	Rent-Equipment & Vehicles			6,495	6,495		6,495	93	6,588			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			102,262	102,262		102,262	(46,117)	56,145			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			167,952	167,952		167,952		167,952			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,549	43,549		43,549		43,549			42
43	Other (specify):* <b>Non-allowable Costs</b>			664	664		664	(664)				43
44	<b>TOTAL Special Cost Centers</b>			212,165	212,165		212,165	(664)	211,501			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	291,914	79,208	486,093	857,215		857,215	(51,169)	806,046			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: 1/1/2014

Ending: 12/31/2014

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(198)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(132)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(664)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(35,000)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (35,994)</b>		<b>\$</b>	<b>30</b>

BHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(15,175)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (15,175)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (51,169)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

North Kickapoo

ID# 0047290

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

Sch. V Line

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

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(35,000)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Kickapoo# 0047290

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

## 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)	
	<b>A. General Services</b>													
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	267	0	0	0	0	0	0	0	0	0	267	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	267	0	0	0	0	0	0	0	0	0	267	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	(7,847)	0	0	0	0	0	0	0	0	0	(7,847)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(132)	489	0	0	0	0	0	0	0	0	0	357	19
20	Fees, Subscriptions & Promotions	0	27	0	0	0	0	0	0	0	0	0	27	20
21	Clerical & General Office Expenses	0	113	0	0	0	0	0	0	0	0	0	113	21
22	Employee Benefits & Payroll Taxes	0	2,695	0	0	0	0	0	0	0	0	0	2,695	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(132)	(4,523)	0	0	0	0	0	0	0	0	0	(4,655)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(132)	(4,256)	0	0	0	0	0	0	0	0	0	(4,388)	29



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Kickapoo# 0047290

Report Period Beginning:

1/1/2014 Ending:

12/31/2014

## 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)	
	<b>D. Ownership</b>													
30	Depreciation	0	12,752	0	0	0	0	0	0	0	0	0	12,752	30
31	Amortization of Pre-Op. & Org.	(35,000)	0	0	0	0	0	0	0	0	0	0	(35,000)	31
32	Interest	(198)	12,440	0	0	0	0	0	0	0	0	0	12,242	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	93	0	0	0	0	0	0	0	0	0	93	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(35,198)</b>	<b>(10,919)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(46,117)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(664)	0	0	0	0	0	0	0	0	0	0	(664)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(664)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(664)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(35,994)</b>	<b>(15,175)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(51,169)</b>	<b>45</b>

**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 Enterprises	Decatur, IL	Real Estate
		Joe Jac Spring Creek Terrace	Decatur	A Step Forward	Decatur, IL	Day Training & 3 CILAs

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	6 Maintenance	\$	J&J Maupin Enterprises	100.00%	\$ 267	\$	267	1
2	V	17 Administrative	29,400	J&J Maupin Enterprises	100.00%	21,553		(7,847)	2
3	V	19 Professional Fees		J&J Maupin Enterprises	100.00%	489		489	3
4	V	20 Dues, Subscriptions, Licenses		J&J Maupin Enterprises	100.00%	27		27	4
5	V	21 Clerical & General Admin		J&J Maupin Enterprises	100.00%	113		113	5
6	V	22 Employee Benefits		J&J Maupin Enterprises	100.00%	2,695		2,695	6
7	V	30 Depreciation		J&J Maupin Enterprises	100.00%	12,752		12,752	7
8	V	32 Interest		J&J Maupin Enterprises	100.00%	12,440		12,440	8
9	V	35 Rent-Equipment		J&J Maupin Enterprises	100.00%	93		93	9
10	V	34 Rent	36,204	J&J Maupin Enterprises	100.00%			(36,204)	10
11	V			J&J Maupin Enterprises	100.00%				11
12	V								12
13	V								13
14	Total		\$ 65,604			\$ 50,429	\$ *	(15,175)	14

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

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/2014 Ending: 12/31/2014

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeremy Maupin	President	Administrative	100.00	74,052	15	25.00	Salary	\$ 21,447	L17, C 7	1
2	Jennifer Maupin	Controller	Other Admin	0.00	367	10	33.33	Salary	106	L17, C7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,553		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:

1/1/2014

Ending: 2/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Revenue	3,944,362	4	\$ 1,192	\$ 885,818	\$ 267	1
2	17	Administrative	Revenue	3,944,362	4	95,972	885,818	21,553	2
3	19	Professional Fees	Revenue	3,944,362	4	2,181	885,818	489	3
4	20	Dues, Subscriptions, Licenses	Revenue	3,944,362	4	118	885,818	27	4
5	21	Clerical & General Admin	Revenue	3,944,362	4	504	885,818	113	5
6	22	Employee Benefits	Revenue	3,944,362	4	12,005	885,818	2,695	6
7	30	Depreciation	Revenue	3,944,362	4	56,784	885,818	12,752	7
8	32	Interest	Revenue	3,944,362	4	55,394	885,818	12,440	8
9	35	Rent-Equipment	Revenue	3,944,362	4	415	885,818	93	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					\$ 224,565	\$ 95,972	\$ 50,429	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	First Mid IL Bank & Trust		X	Facility	\$3,388.74	10/26/05	\$ 366,667	\$ 67,460	9/26/2015	4.2500	\$ 3,713						
2																	
3																	
4																	
5																	
<b>Working Capital</b>																	
6	First Mid IL Bank & Trust		X	Line of Credit		9/26/09		18,653	11/12/12	6.0000	3,604						
7	Kim Robinson		X	Working Capital	\$1,130.44	9/16/05	170,000	89,762	8/16/2015	6.5000	6,556						
8	RBS Citizens Bank		X	Auto Loan	\$394.92	11/14/14	22,124	19,297	11/14/19	2.1400							
9	<b>TOTAL Facility Related</b>				<b>\$4,914.10</b>		<b>\$ 558,791</b>	<b>\$ 195,172</b>			<b>\$ 13,873</b>						
<b>B. Non-Facility Related*</b>																	
10																	
11											12,440						
12											(198)						
13																	
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$ 12,242</b>						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 558,791</b>	<b>\$ 195,172</b>			<b>\$ 26,115</b>						

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

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

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

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

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2013 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.)	2013		\$	8,386	2	
3. Under or (over) accrual (line 2 minus line 1).			\$	8,386	3	
4. Real Estate Tax accrual used for 2014 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	8,386	7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	10,738	8	<b>FOR BHF USE ONLY</b>		
	2010	10,626	9			
	2011	10,904	10			
	2012	8,212	11			
	2013	8,386	12			
				13	FROM R. E. TAX STATEMENT FOR 2013 \$	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.**

## 2013 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 2013 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 2013.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>08-029-015-50</u>	<u>Facility</u>	\$ <u>8,385.86</u>	\$ <u>8,385.86</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>8,385.86</u></u>	\$ <u><u>8,385.86</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES        X   NO

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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:

1/1/2014 Ending:

12/31/2014

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 5,000 B. General Construction Type: Exterior Brick/Vinyl Frame Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9		Parking Lot	2009		500	33	15	33		150
10		Carpeting - 2 living rooms, bedrooms 4 & 5	2013		1,934	193	10	193		290
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						12,752	12,752	
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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,434	\$ 226		\$ 12,978	\$ 12,752	\$ 440	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 75,373	\$ 1,215	\$ 1,215	\$	5-10 yrs	\$ 56,667	71
72	Current Year Purchases	9,120	456	456		5-10 yrs	456	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 84,493	\$ 1,671	\$ 1,671	\$		\$ 57,123	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Program Transportation	2002 Dodge Caravan	2005	\$ 2,500	\$	\$	\$	5 yr	\$ 2,500	76
77	Program Transportation	2006 Dodge Caravan	2007	18,523				5 yr	18,523	77
78	Program Transportation	2014 Ford Transit	2014	24,433	407	407		5 yr	407	78
79										79
80	TOTALS			\$ 45,456	\$ 407	\$ 407	\$		\$ 21,430	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)	\$ 132,383	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 2,304	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,056	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,752	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 78,993	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning: 1/1/2014

Ending: 12/31/2014

**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:				\$	1		3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 93

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	\$ (25)	17
18	Administrative	2014 Honda Oddesey	501.55	6,520	18
19					19
20					20
21	TOTAL		\$ 1,070.89	\$ 6,495	21

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>40</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>80</u></p>
--	---	--

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		6,629		6,629
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 6,629	\$	\$ 6,629
10	SUM OF line 9, col. 1 and 2 (e)	\$	6,629		

**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	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>8</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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 prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Day Training</u>	<u>39(3)</u>				<u>167,952</u>			<u>167,952</u>	13	
14	<b>TOTAL</b>			\$		\$ <u>167,952</u>	\$		\$ <u>167,952</u>	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.

Facility Name & ID Number North Kickapoo# 0047290Report Period Beginning: 1/1/2014Ending: 12/31/2014

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2014

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 47,682	\$ 47,682	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	82,231	82,231	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)	4,478	4,478	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 134,391	\$ 134,391	10
	<b>B. Long-Term Assets</b>			
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	131,883	129,949	16
17	Accumulated Depreciation (book methods)	(78,993)	(78,993)	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 (spec <u>Goodwill</u> )	201,250	201,250	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 254,640	\$ 254,640	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 389,031	\$ 389,031	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 20,095	\$ 20,095	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	9,375	9,375	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	487	487	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 29,957	\$ 29,957	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	127,712	127,712	39
40	Mortgage Payable	67,460	67,460	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 195,172	\$ 195,172	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 225,129	\$ 225,129	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 163,902	\$ 163,902	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 389,031	\$ 389,031	48

\*(See instructions.)



XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 175,299	1
2	Restatements (describe):		2
3	Prior period adjustments		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 175,299	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	28,603	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	(40,000)	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)	\$ (11,397)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 163,902	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1		
I. Revenue		Amount		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 714,682	1	
2	Discounts and Allowances for all Levels		2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 714,682	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8	
<b>C. Other Operating Revenue</b>				
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	198	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 198	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<b>Workshop Revenue</b>	168,595	28	
28a	<b>EIC \$1,663, Transportation Income \$680</b>	2,343	28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 170,938	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 885,818	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	153,319	31	
32	Health Care	245,699	32	
33	General Administration	143,770	33	
<b>B. Capital Expense</b>				
34	Ownership	102,262	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	168,616	35	
36	Provider Participation Fee	43,549	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 857,215	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	28,603	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 28,603	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 714,682	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 714,682	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:

1/1/2014

Ending:

12/31/2014

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing		\$	\$	1	
2	Assistant Director of Nursing				2	
3	Registered Nurses	286	516	14,873	28.82	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	691	691	6,629	9.59	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,940	1,988	20,898	10.51	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,527	3,735	43,402	11.62	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,615	1,799	21,403	11.90	18
19	Laundry					19
20	Administrator	570	570	24,496	42.98	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)	1,904	2,080	44,701	21.49	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	11,003	11,571	115,512	9.98	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,536	22,950	\$ 291,914 *	\$ 12.72	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 1,296	L1, C3	35
36	Medical Director	Monthly	7,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	6,000	L10, C3	38
39	Pharmacist Consultant	Monthly	613	L10, C3	39
40	Physical Therapy Consultant	Monthly	390	L10a, C3	40
41	Occupational Therapy Consultant	Monthly	162	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	926	L10a, C3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental</u>	Monthly	2,833	L10, C3	46
47	<u>Psychologist</u>	Monthly	810	L10, C3	47
48	<u>Podiatry</u>	Monthly	602	L10, C3	48
49	TOTAL (lines 35 - 48)		\$ 20,832		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Kristi Nottelmann</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 24,496</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 7,924</u>	<u>IDPH License Fee</u>	<u>\$</u>	
				<u>Unemployment Compensation Insurance</u>	<u>3,151</u>	<u>Advertising: Employee Recruitment</u>	<u>(11)</u>	
				<u>FICA Taxes</u>	<u>18,244</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>8,596</u>	<u>(Indicate # of checks performed _____)</u>		
				<u>Employee Meals</u>	<u>17,740</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Licenses and Fees</u>	<u>251</u>	
				<u>Allocated from J &amp; J Maupin Enterprises</u>	<u>2,695</u>	<u>Allocated from J &amp; J Maupin Enterprises</u>	<u>27</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 24,496</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>		<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		
<b>(List each licensed administrator separately.)</b>				<b>\$ 58,350</b>		<b>\$ 267</b>		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			<u>\$ 29,400</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 29,400</b>	<b>TOTAL</b>		<b>\$</b>	<u>Seminar Expense</u>	
<b>(Attach a copy of any management service agreement)</b>							<u>Entertainment Expense</u>	<u>(</u>
C. Professional Services								
Vendor/Payee	Type	Amount						
<u>Kelly's Accounting</u>	<u>Accounting</u>	<u>\$ 5,057</u>						
<u>Templin Healthcare Accounting</u>	<u>Accounting</u>	<u>1,000</u>						
<u>Quickbooks</u>	<u>Payroll Service</u>	<u>289</u>						
<u>Bolen, Robinson, &amp; Ellis, LLP</u>	<u>Legal Services</u>	<u>166</u>						
<u>Duane Morris</u>	<u>Legal Services</u>	<u>893</u>						
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 7,405</b>				<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	
<b>(For legal fee disclosure, see page 39 of instructions)</b>							<b>\$</b>	

\* Attach copy of IMRF notifications

\*\*See instructions.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number North Kickapoo

# 0047290

Report Period Beginning:

1/1/2014

Ending:

12/31/2014

## 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. \$ 2,980 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. \$ 43,549  
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. \$ 17,740 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

North Kickapoo

Period Beginning 1/1/2014  
Period End 12/31/2014

ATTACHED SCHEDULE I

SCHEDULE I - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:

Repairs / Maintenance	577
Fuel and miscellaneous supplies	<u>3,618</u>
	<u><u>4,195</u></u>

**North Kickapoo**

**Period Beginning** 1/1/2014  
**Period End** 12/31/2014

**ATTACHED SCHEDULE II**

**SCHEDULE XX - (12)**

**Wage costs are allocated based on scheduled time.**