		FOR BHF USE					

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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 North Kickapoo St, Box 511 (Number) Lincoln (City) 62656 (Zip Code)

County: Logan

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

HFS ID Number: 38-3723018001

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/08 to 12/31/08 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)	See Attached Compilation Report (Date)
	(Print Name and Title)	James B. Eisenmenger, MS, CPA Member
	(Firm Name & Address)	Martin, Hood, Friese & Associates, LLC 2507 S. Neil Street, Champaign, IL 61820
	(Telephone)	(217) 351-2000 Fax # (217) 351-7726

In the event there are further questions about this report, please contact:
Name: Jeremy Maupin Telephone Number: 217-422-6361
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,856	6
7	16	TOTALS	16	5,856	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	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	5,718			5,718	13
14	TOTALS	5,718			5,718	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.64%

D. How many bed-hold days during this year were paid by the Department?
107 (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]

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 09/16/05 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 NA

Medicare Intermediary NA

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	48,460	1,188	1,258	50,906		50,906		50,906			1
2	Food Purchase		36,786		36,786		36,786	621	37,407			2
3	Housekeeping	34,927	8,409		43,336		43,336		43,336			3
4	Laundry		1,278		1,278		1,278		1,278			4
5	Heat and Other Utilities			18,553	18,553		18,553	(90)	18,463			5
6	Maintenance		4,651	14,859	19,510		19,510	(1,382)	18,128			6
7	Other (specify):*											7
8	TOTAL General Services	83,387	52,312	34,670	170,369		170,369	(851)	169,518			8
	B. Health Care and Programs											
9	Medical Director		3,184	7,240	10,424		10,424		10,424			9
10	Nursing and Medical Records	113,374	3,765	7,260	124,399		124,399		124,399			10
10a	Therapy			3,380	3,380		3,380		3,380			10a
11	Activities	19,714	6,377		26,091		26,091	126	26,217			11
12	Social Services	29,372		1,057	30,429		30,429		30,429			12
13	CNA Training	6,716			6,716		6,716		6,716			13
14	Program Transportation			5,659	5,659		5,659		5,659			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	169,176	13,326	24,596	207,098		207,098	126	207,224			16
	C. General Administration											
17	Administrative	58,494			58,494		58,494		58,494			17
18	Directors Fees											18
19	Professional Services			11,429	11,429		11,429	368	11,797			19
20	Dues, Fees, Subscriptions & Promotions			3,293	3,293		3,293	60	3,353			20
21	Clerical & General Office Expenses		1,882	10,027	11,909		11,909	(4,394)	7,515			21
22	Employee Benefits & Payroll Taxes			55,917	55,917		55,917		55,917			22
23	Inservice Training & Education			491	491		491		491			23
24	Travel and Seminar							762	762			24
25	Other Admin. Staff Transportation			8,232	8,232		8,232	(1,987)	6,245			25
26	Insurance-Prop.Liab.Malpractice			8,666	8,666		8,666		8,666			26
27	Other (specify):*											27
28	TOTAL General Administration	58,494	1,882	98,055	158,431		158,431	(5,191)	153,240			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	311,057	67,520	157,321	535,898		535,898	(5,916)	529,982			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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: 01/01/08 Ending: 12/31/08

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			10,458	10,458		10,458	19,950	30,408			30
31	Amortization of Pre-Op. & Org.			35,000	35,000		35,000	(35,000)				31
32	Interest			37,295	37,295		37,295	3,316	40,611			32
33	Real Estate Taxes			10,064	10,064		10,064		10,064			33
34	Rent-Facility & Grounds			36,204	36,204		36,204	(36,204)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			129,021	129,021		129,021	(47,938)	81,083			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			186,217	186,217		186,217		186,217			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,250	39,250		39,250		39,250			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			225,467	225,467		225,467		225,467			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	311,057	67,520	511,809	890,386		890,386	(53,854)	836,532			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	(696)	5-3		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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Amortization of Goodwill	(35,000)	31-3		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,696)		$	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)	(14,918)		34
35	Other- Attach Schedule Schedule VIII	(3,240)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (18,158)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (53,854)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

North Kickapoo

ID# 0047290

Report Period Beginning: 01/01/08

Ending: 12/31/08

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	(1,596)	0	0	0	0	0	0	0	0	0	(1,596)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	(1,596)	0	0	0	0	0	0	0	0	0	(1,596)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	353	0	0	0	0	0	0	0	0	0	353	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	27	0	0	0	0	0	0	0	0	0	27	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	260	0	0	0	0	0	0	0	0	0	260	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	640	0	0	0	0	0	0	0	0	0	640	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(956)	0	0	0	0	0	0	0	0	0	(956)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	19,950	0	0	0	0	0	0	0	0	0	19,950	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	2,292	0	0	0	0	0	0	0	0	0	2,292	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	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(13,962)	0	0	0	0	0	0	0	0	0	(13,962)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(14,918)	0	0	0	0	0	0	0	0	0	(14,918)	45

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if 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	Lincoln	J&J Maupin		
Jeremy Maupin	100	Joe Jac Spring Creek Terrace	Decatur	Enterprises	Decatur	Real Estate

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 36,204	J&J Maupin Enterprises	100.00%	$	$ (36,204)	1
2	V	6	Maintenance	1,610	J&J Maupin Enterprises	100.00%		(1,610)	2
3	V	25	Administrative Transportation	2,100	J&J Maupin Enterprises	100.00%		(2,100)	3
4	V	19	Professional Services		J&J Maupin Enterprises	100.00%	353	353	4
5	V	20	Licenses and Fees		J&J Maupin Enterprises	100.00%			5
6	V	25	Administrative Transportation		J&J Maupin Enterprises	100.00%	2,360	2,360	6
7	V	6	Maintenance		J&J Maupin Enterprises	100.00%	14	14	7
8	V	30	Depreciation		J&J Maupin Enterprises	100.00%	19,950	19,950	8
9	V	32	Interest		J&J Maupin Enterprises	100.00%	28,942	28,942	9
10	V	21	Office Expense		J&J Maupin Enterprises	100.00%	27	27	10
11	V	32	Interest	26,650	J&J Maupin Enterprises	100.00%		(26,650)	11
12	V								12
13	V								13
14	Total			$ 66,564			$ 51,646	$ * (14,918)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Jeremy Maupin	President	Administrative	100.00	39,714	15	25.00	Salary	$ 17,213	17(1)	1
2	Jennifer Maupin	Controller	Other Admin	0.00	8,162	10	33.00	Salary	4,081	17(1)	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 21,294		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

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: Central Office
Street Address:
City / State / Zip Code:
Phone Number: (
Fax Number: (

	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						$	$		$	1
2	2	Food	Beds & Bed Equivalents	64	4	2,485		16	621	2
3	3	Housekeeping	Beds & Bed Equivalents	64	4			16	0	3
4	5	Utilities	Beds & Bed Equivalents	64	4	2,424		16	606	4
5	6	Maintenance	Beds & Bed Equivalents	64	4	1,096		16	274	5
6	9	Medical Director	Beds & Bed Equivalents	64	4			16	0	6
7	11	Activities	Beds & Bed Equivalents	64	4	505		16	126	7
8	19	Professional Fees	Beds & Bed Equivalents	64	4	60		16	15	8
9	20	Dues, Licenses & Subscriptions	Beds & Bed Equivalents	64	4	238		16	60	9
10	21	Office	Beds & Bed Equivalents	64	4	15,036		16	3,759	10
11	24	Travel and Seminar	Beds & Bed Equivalents	64	4	3,049		16	762	11
12	25	Administrative Travel	Beds & Bed Equivalents	64	4	3,126		16	782	12
13	32	Interest	Beds & Bed Equivalents	64	4	4,094		16	1,024	13
14										14
15	21	Central Office Fees Paid							(8,180)	15
16	6	Maintenance							(60)	16
17	25	Administrative Travel							(3,029)	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 32,113	$		$ (3,240)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	Net Schedule VII Allocation		X								2,292	2
3	First Mid IL Bank & Trust		X	Facility	$4,257.37	10/26/05	366,667	274,202	9/26/2015	7.2500	23,232	3
4	Vehicle Loan		X	Vehicle	$262.19	5/3/07	13,528	9,472	5/3/2012	6.0000	690	4
5												5
	Working Capital											
6	Schedule VIII Allocation		X	Working Capital							1,024	6
7	First Mid IL Bank & Trust		X	Line of Credit		9/26/08		146,550	3/16/09	7.2500	3,775	7
8	Kim Robinson		X	Working Capital	$1,930.00	9/16/05	170,000	125,337	8/16/2015	6.5000	9,598	8
9	TOTAL Facility Related				$6,449.56		$ 550,195	$ 555,561			$ 40,611	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 550,195	$ 555,561			$ 40,611	15

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

** 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: 01/01/08 Ending: 12/31/08

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 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.)	$ 10,064	2
3. Under or (over) accrual (line 2 minus line 1).	$ 10,064	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 10,064	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2003	8,338	8
	2004	8,755	9
	2005	9,172	10
	2006	9,591	11
	2007	10,064	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 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 2007 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 2007.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-029-015-50	Facility	$ 10,064.00	$ 10,064.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 10,064.00	$ 10,064.00

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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: 01/01/08 Ending: 12/31/08

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 [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

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

1. Total Amount Incurred: NA
2. Number of Years Over Which it is Being Amortized: NA
3. Current Period Amortization: NA
4. Dates Incurred: NA

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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											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

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)		$	$		$	$	$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 37,321	$ 6,216	$ 6,216	$	5-7 yr	$ 25,904	71
72	Current Year Purchases	511	37	37		7 yr	37	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 37,832	$ 6,253	$ 6,253	$		$ 25,941	75

D. Vehicle Depreciation (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	$ 500	$ 500	$	5	$ 2,300	76
77	Program Transportation	2006 Dodge Caravan	2007	18,523	3,705	3,705		5	6,175	77
78										78
79										79
80	TOTALS			$ 21,023	$ 4,205	$ 4,205	$		$ 8,475	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)	$ 58,855	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 10,458	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 10,458	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 34,416	85	

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

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

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: J&J Enterprises
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1988	16	09/16/05	$ 36,204	Monthly		3
4	Additions							4
5								5
6								6
7	TOTAL		16		$ 36,204 **			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 NA .

9. Option to Buy: [ ] YES [X] 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.		$
13.		$
14.		$

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: $ NA Description: NA
(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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		6,716		6,716
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 6,716	$	$ 6,716
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,716			

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	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	9
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
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					186,217			186,217	13
14	TOTAL			$		$ 186,217	$		$ 186,217	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/08 (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	$ (6,045)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	170,899		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)	20,777		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 185,631	$	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			15
16	Equipment, at Historical Cost	58,855		16
17	Accumulated Depreciation (book methods)	(34,416)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	411,250		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 435,689	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 621,320	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,513	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,571		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,000		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Line of Credit	146,550		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 169,634	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	134,809		39
40	Mortgage Payable	274,202		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)**	$ 409,011	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 578,645	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 42,675	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 621,320	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 35,765	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 35,765	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	6,910	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 6,910	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)**	$ 42,675	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

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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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 710,199	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 710,199	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	187,097	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 187,097	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 897,296	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	170,369	31
32	Health Care	207,098	32
33	General Administration	158,431	33
	B. Capital Expense		
34	Ownership	129,021	34
	C. Ancillary Expense		
35	Special Cost Centers	186,217	35
36	Provider Participation Fee	39,250	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 890,386	40
41	**Income before Income Taxes (line 30 minus line 40)****	6,910	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 6,910	43

* 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. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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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	610	610	14,909	24.44	3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	750	750	6,716	8.95	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,478	1,526	16,556	10.85	9
10	Activity Assistants	368	368	3,158	8.58	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,103	4,471	48,460	10.84	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,946	3,098	34,927	11.27	18
19	Laundry					19
20	Administrator	1,390	1,445	41,826	28.95	20
21	Assistant Administrator					21
22	Other Administrative	1,101	1,145	16,668	14.56	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)	1,402	1,458	29,372	20.15	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	9,990	10,366	98,465	9.50	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,138	25,237	$ 311,057 *	$ 12.33	34

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* 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		$ 1,259	1(3)	35
36	Medical Director		7,240	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant		1,100	10(3)	38
39	Pharmacist Consultant		363	10(3)	39
40	Physical Therapy Consultant		699	10a(3)	40
41	Occupational Therapy Consultant		211	10a(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		2,470	10a(3)	43
44	Activity Consultant				44
45	Social Service Consultant		1,057	12(3)	45
46	Other(specify) Dentist		2,752	10(3)	46
47	Podiatrist		345	10(3)	47
48	Psychologist		2,700	10(3)	48
49	TOTAL (lines 35 - 48)		$ 20,196		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Maupin	Admin	100	$ 17,213
Jennifer Maupin	Other Admin	0	4,081
Kristi Nottelmann	Other Admin	0	25,702
Janice Ernst	QMRP/Other Admin	0	11,498
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 58,494

B. Administrative - Other

Description	Amount
None	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Kelly's Accounting	Accounting	$ 4,838
Martin, Hood, Friese & Associates	Accounting	2,900
Duane Morris	Legal	2,034
Bolen, Robinson & Ellis LLP	Legal	1,657
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 11,429

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 7,341
Unemployment Compensation Insurance	3,903
FICA Taxes	23,796
Employee Health Insurance	10,829
Employee Meals	6,897
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contributions	3,151
TOTAL (agree to Schedule V, line 22, col.8)	$ 55,917

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

Description	Line #	Amount
None		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	867
Health Care Worker Background Check (Indicate # of checks performed 12)	234
Patient Background Checks	
IHCA Dues	810
Licenses and Fees	1,382
Schedule VIII Allocation	60
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,353

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	0
Schedule VIII Allocation	762
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 762

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

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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								
					FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 01/01/08 Ending: 12/31/08

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? **Yes**
If YES, give association name and amount. **IHCA $810**

(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? **NA**

(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? **NA**

(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? **5-7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,313** Line **210**

(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. **NA**

(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.
NA

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **39,250**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **6,897** Has any meal income been offset against related costs? **No** Indicate the amount. $ **NA**

(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. $ **NA**
c. What percent of all travel expense relates to transportation of nurses and patients? **48**
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? **NA**
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. $ **NA**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **NA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NA** If no, please explain. **NA**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **NA**
Attach invoices and a summary of services for all architect and appraisal fees.