



Facility Name & ID Number Hickory Point Terrace

# 0047282 Report Period Beginning: 1/1/2013 Ending: 12/31/13

III. STATISTICAL DATA

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

	1	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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	5,678			5,678
14	TOTALS	5,678			5,678

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.23%

D. How many bed-hold days during this year were paid by the Department? 77 (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

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/13 Fiscal Year: 12/31/13

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

Facility Name &amp; ID Number

Hickory Point Terrace

# 0047282

Report Period Beginning:

1/1/2013

Ending:

12/31/13

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

	Operating Expenses	Costs Per General Ledger				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	42,636	1,077	966	44,679		44,679	44,679			1
2	Food Purchase		23,630		23,630		23,630	23,630			2
3	Housekeeping	18,753	24,280		43,033		43,033	43,033			3
4	Laundry		145		145		145	145			4
5	Heat and Other Utilities			12,861	12,861		12,861	12,861			5
6	Maintenance		2,934	19,194	22,128		22,128	219	22,347		6
7	Other (specify):* <b>Waste Removal</b>			1,599	1,599		1,599		1,599		7
8	<b>TOTAL General Services</b>	61,389	52,066	34,620	148,075		148,075	219	148,294		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,500	7,500		7,500	7,500			9
10	Nursing and Medical Records	169,971	7,047	6,575	183,593		183,593	183,593			10
10a	Therapy			1,739	1,739		1,739	1,739			10a
11	Activities	25,804	8,443		34,247		34,247	34,247			11
12	Social Services										12
13	CNA Training	8,208			8,208		8,208	8,208			13
14	Program Transportation			12,917	12,917		12,917	(5,422)	7,495		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	203,983	15,490	28,731	248,204		248,204	(5,422)	242,782		16
	<b>C. General Administration</b>										
17	Administrative	7,434		10,400	17,834		17,834	9,303	27,137		17
18	Directors Fees										18
19	Professional Services			7,400	7,400		7,400	328	7,728		19
20	Dues, Fees, Subscriptions & Promotions			3,689	3,689		3,689	30	3,719		20
21	Clerical & General Office Expenses		3,931	6,826	10,757		10,757	34	10,791		21
22	Employee Benefits & Payroll Taxes			48,491	48,491		48,491	5,748	54,239		22
23	Inservice Training & Education			298	298		298		298		23
24	Travel and Seminar			441	441		441		441		24
25	Other Admin. Staff Transportation			3,294	3,294		3,294	282	3,576		25
26	Insurance-Prop.Liab.Malpractice			10,593	10,593		10,593	93	10,686		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	7,434	3,931	91,432	102,797		102,797	15,818	118,615		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	272,806	71,487	154,783	499,076		499,076	10,615	509,691		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 &amp; ID Number

Hickory Point Terrace

#0047282

Report Period Beginning:

1/1/2013

Ending:

12/31/13

## 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			1,518	1,518	1,518	14,040	15,558				30
31	Amortization of Pre-Op. & Org.			40,000	40,000	40,000	(40,000)					31
32	Interest			16,489	16,489	16,489	13,654	30,143				32
33	Real Estate Taxes			6,507	6,507	6,507		6,507				33
34	Rent-Facility & Grounds			97,404	97,404	97,404	(36,204)	61,200				34
35	Rent-Equipment & Vehicles			3,771	3,771	3,771	78	3,849				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			165,689	165,689	165,689	(48,432)	117,257				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			205,645	205,645	205,645		205,645				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,657	45,657	45,657		45,657				42
43	Other (specify):* <b>Non-allowable Costs</b>											43
44	<b>TOTAL Special Cost Centers</b>			251,302	251,302	251,302		251,302				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	272,806	71,487	571,774	916,067	916,067	(37,817)	878,250				45

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

Facility Name & ID Number Hickory Point Terrace

# 0047282

Report Period Beginning: 1/1/2013

Ending: 12/31/13

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(478)	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				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(45,140)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (45,618)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>					
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	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	7,801		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 7,801</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (37,817)</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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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>

Hickory Point Terrace

ID# 0047282

Report Period Beginning: 1/1/2013

Ending: 12/31/13

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Transportation Income	\$ (460)	14	1
2	Disallow Amortization	(40,000)	31	2
3	Offset Miscellaneous Income	(100)	14	3
4	Disallow non-facility vehicle gas expense	(5,483)	14	4
5	Additional Vehicle gas expense	621	14	5
6	Additional Vehicle gas expense	282	25	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>		(45,140)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hickory Point Terrace# 0047282

Report Period Beginning:

1/1/2013

Ending:

12/31/13

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	219	0	0	0	0	0	0	0	0	0	219	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>0</b>	<b>219</b>	<b>0</b>	<b>219</b>	<b>8</b>								
	<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	(5,422)	0	0	0	0	0	0	0	0	0	0	(5,422)	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>	<b>(5,422)</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>(5,422)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	9,303	0	0	0	0	0	0	0	0	0	9,303	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	328	0	0	0	0	0	0	0	0	0	328	19
20	Fees, Subscriptions & Promotions	0	30	0	0	0	0	0	0	0	0	0	30	20
21	Clerical & General Office Expenses	0	34	0	0	0	0	0	0	0	0	0	34	21
22	Employee Benefits & Payroll Taxes	0	5,748	0	0	0	0	0	0	0	0	0	5,748	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	282	0	0	0	0	0	0	0	0	0	0	282	25
26	Insurance-Prop.Liab.Malpractice	0	93	0	0	0	0	0	0	0	0	0	93	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>282</b>	<b>15,536</b>	<b>0</b>	<b>15,818</b>	<b>28</b>								
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(5,140)</b>	<b>15,755</b>	<b>0</b>	<b>10,615</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hickory Point Terrace

# 0047282

Report Period Beginning:

1/1/2013 Ending:

12/31/13

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	0	14,040	0	0	0	0	0	0	0	0	0	14,040	30
31	Amortization of Pre-Op. & Org.	(40,000)	0	0	0	0	0	0	0	0	0	0	(40,000)	31
32	Interest	(478)	14,132	0	0	0	0	0	0	0	0	0	13,654	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	78	0	0	0	0	0	0	0	0	0	78	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(40,478)</b>	<b>(7,954)</b>	<b>0</b>	<b>(48,432)</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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</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>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(45,618)</b>	<b>7,801</b>	<b>0</b>	<b>(37,817)</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 North Kickapoo	Lincoln	J&J Maupin Enterprises	Decatur, IL	Real Estate
		Joe Jac Spring Creek Terrace	Decatur	A Step Forward	Decatur, IL	Day Training
		Burgener Drive	Decatur			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  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%	\$ 219	\$	219	1
2	V	17 Administrative	10,400	J&J Maupin Enterprises	100.00%	19,703		9,303	2
3	V	19 Professional Fees		J&J Maupin Enterprises	100.00%	328		328	3
4	V	20 Dues, Subscriptions, Licenses		J&J Maupin Enterprises	100.00%	30		30	4
5	V	21 Clerical & General Admin		J&J Maupin Enterprises	100.00%	34		34	5
6	V	22 Employee Benefits		J&J Maupin Enterprises	100.00%	5,748		5,748	6
7	V	26 Insurance		J&J Maupin Enterprises	100.00%	93		93	7
8	V	30 Depreciation		J&J Maupin Enterprises	100.00%	14,040		14,040	8
9	V	32 Interest		J&J Maupin Enterprises	100.00%	14,132		14,132	9
10	V	35 Rent-Equipment		J&J Maupin Enterprises	100.00%	78		78	10
11	V	34 Rent	36,204	J&J Maupin Enterprises	100.00%			(36,204)	11
12	V								12
13	V								13
14	Total		\$ 46,604			\$ 54,405	\$ *	7,801	14

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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2013 Ending: 12/31/13

## VII. RELATED PARTIES (continued)

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

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

	1 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	53,085	15	25.00	Salary	\$ 16,660	L17, C 7	1
2	Jeremy Maupin	President	Administrative	100.00	12,815	15	25.00	Pension	4,022	L22, C7	2
3	Jennifer Maupin	Controller	Other Admin	0.00	9,695	10	33.33	Salary	3,043	L17, C7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 23,725		13

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

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

Facility Name & ID Number Hickory Point Terrace

# 0047282

Report Period Beginning:

1/1/2013

Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  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	3,906,682	4	\$ 917	\$ 933,207	\$ 219	1
2	17	Administrative	Revenue	3,906,682	4	82,481	82,481	19,703	2
3	19	Professional Fees	Revenue	3,906,682	4	1,372	933,207	328	3
4	20	Dues, Subscriptions, Licenses	Revenue	3,906,682	4	127	933,207	30	4
5	21	Clerical & General Admin	Revenue	3,906,682	4	143	933,207	34	5
6	22	Employee Benefits	Revenue	3,906,682	4	24,059	933,207	5,748	6
7	26	Insurance	Revenue	3,906,682	4	388	933,207	93	7
8	30	Depreciation	Revenue	3,906,682	4	58,776	933,207	14,040	8
9	32	Interest	Revenue	3,906,682	4	59,162	933,207	14,132	9
10	35	Rent-Equipment	Revenue	3,906,682	4	325	933,207	78	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 227,750	\$ 82,481	\$ 54,405	25

Facility Name &amp; ID Number

Hickory Point Terrace

# 0047282

Report Period Beginning:

1/1/2013

Ending:

12/31/13

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
	<b>A. Directly Facility Related</b>															
	<b>Long-Term</b>															
1	First Mid IL Bank & Trust		X	Facility	\$3,389.00	10/26/05	\$ 366,667	\$ 104,412	9/26/2015	4.2500	\$ 5,238	1				
2												2				
3												3				
4												4				
5												5				
	<b>Working Capital</b>															
6	First Mid IL Bank & Trust		X	Line of Credit		9/26/09		29,848	11/12/12	6.0000	4,808	6				
7	Kim Robinson		X	Working Capital	\$1,130.00	9/16/05	170,000	96,772	8/16/2015	6.5000	6,443	7				
8												8				
9	<b>TOTAL Facility Related</b>				\$4,519.00		\$ 536,667	\$ 231,032			\$ 16,489	9				
	<b>B. Non-Facility Related*</b>															
10												10				
11											14,132	11				
12											(478)	12				
13												13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 13,654	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 536,667	\$ 231,032			\$ 30,143	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # \_\_\_\_\_\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

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

**B. Real Estate Taxes**

<p><b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b></p>			
1. Real Estate Tax accrual used on 2012 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2012	\$	2
		6,507	
3. Under or (over) accrual (line 2 minus line 1).		\$	3
		6,507	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <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.		\$	7
		6,507	
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2008	6,576	8
	2009	6,605	9
	2010	6,719	10
	2011	6,695	11
	2012	6,507	12
<b>FOR BHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

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

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hickory Point Terrace COUNTY Macon  
 FACILITY IDPH LICENSE NUMBER 0047282  
 CONTACT PERSON REGARDING THIS REPORT Jeremy Maupin  
 TELEPHONE 217-422-6361 FAX #: 217-422-6365

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

(A)	(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>07-07-23-101-005</u>	<u>Facility</u>	\$ <u>6,507.00</u>	\$ <u>6,507.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>6,507.00</u></u>	\$ <u><u>6,507.00</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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Hickory Point Terrace

# 0047282 Report Period Beginning:

1/1/2013 Ending:

12/31/13

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 4,030 B. General Construction Type: Exterior Brick/Vinyl Frame Wood Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (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

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	Flooring		2009	6,216	324	15	324		1,449	9
10	Parking Lot		2010	9,769	509	15	509		1,954	10
11	Carpet		2012	652	65	10	65		118	11
12	Fencing		2012	1,459	101	10	101		219	12
13	Carpeting - kitchen, bedrooms 1-4		2013	3,868	193	10	193		193	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						14,040	14,040		23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hickory Point Terrace

# 0047282

Report Period Beginning:

1/1/2013

Ending:

12/31/13

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$ 21,964	\$ 1,192		\$ 15,232	\$ 14,040	\$ 3,933	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	\$ 45,877	\$ 196	\$ 196	\$	5-10 yrs	\$ 37,388	71
72	Current Year Purchases	2,611	130	130			130	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 48,488	\$ 326	\$ 326	\$		\$ 37,518	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Program	2003 Dodge Caravan	2005	\$ 2,500	\$	\$	\$	5 yr	\$ 2,500	76
77										77
78										78
79										79
80	TOTALS			\$ 2,500	\$	\$	\$		\$ 2,500	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 72,952	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,518	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,558	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,040	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 43,951	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Hickory Point Terrace

# 0047282

Report Period Beginning: 1/1/2013

Ending: 12/31/13

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Kim Robinson

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

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:	<u>1998</u>	<u>16</u>	<u>09/16/05</u>	\$ <u>61,200</u>	<u>1</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>16</b>		\$ <b>61,200</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 9/17/13

Ending 9/16/14

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

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

12. /2014 \$ \_\_\_\_\_

13. /2015 \$ \_\_\_\_\_

14. /2016 \$ \_\_\_\_\_

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

This amount was calculated by dividing the total amount to be amortized

by the length of the lease N/A.

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 78 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	<u>Administrative</u>	<u>2011 Toyota Prius</u>	\$ <u>314.22</u>	\$ <u>3,771</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>314.22</b>	\$ <b>3,771</b>	<b>21</b>

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

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

Facility Name & ID Number Hickory Point Terrace # 0047282 Report Period Beginning: 1/1/2013 Ending: 12/31/13  
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<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)		8,208		8,208
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 8,208	\$	\$ 8,208
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,208		

**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	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>11</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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): <b>Day Training</b>	<b>39 (3)</b>				<b>205,645</b>			<b>205,645</b>	13
14	<b>TOTAL</b>			\$		\$ <b>205,645</b>	\$		\$ <b>205,645</b>	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 Hickory Point Terrace# 0047282Report Period Beginning: 1/1/2013

Ending:

12/31/13

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	101,983	101,983	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	2,200	2,200	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 104,183	\$ 104,183	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	22,560	21,964	15
16	Equipment, at Historical Cost	50,392	50,988	16
17	Accumulated Depreciation (book methods)	(43,951)	(43,951)	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):	204,916	204,916	22
23	Other(specify): <u>Amortizable Lease</u>	50,000	50,000	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 283,917	\$ 283,917	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 388,100	\$ 388,100	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ (379)	\$ (379)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,399	13,399	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,358	1,358	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Party</u>	100,661	100,661	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 115,039	\$ 115,039	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	126,620	126,620	39
40	Mortgage Payable	104,412	104,412	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43		(585)	(585)	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 230,447	\$ 230,447	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 345,486	\$ 345,486	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 42,614	\$ 42,614	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 388,100	\$ 388,100	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>29,458</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior period adjustments</b>	<b>(3,984)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>25,474</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>17,140</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>17,140</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>42,614</b>	<b>24</b> *

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

Facility Name & ID Number Hickory Point Terrace# 0047282Report Period Beginning: 1/1/2013

Ending:

12/31/13

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

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

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 680,781	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 680,781	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	41,742	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>	\$ 41,742	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	150	24
25	Interest and Other Investment Income***	478	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 628	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Workshop Revenue</b>	205,730	28
28a	<b>EIC \$3766, Transportation Income \$560</b>	4,326	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 210,056	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 933,207	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	148,075	31
32	Health Care	248,204	32
33	General Administration	102,797	33
<b>B. Capital Expense</b>			
34	Ownership	165,689	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	205,645	35
36	Provider Participation Fee	45,657	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 916,067	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	17,140	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 17,140	43

		3	
III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 680,781	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>	\$ 680,781	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Hickory Point Terrace

# 0047282

Report Period Beginning:

1/1/2013

Ending:

12/31/13

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

(This schedule must cover the entire reporting period.)

	1	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	680	18,388	27.04	3
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees	871	8,208	9.42	6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,760	18,148	10.11	9
10	Activity Assistants	767	7,656	9.98	10
11	Social Service Workers				11
12	Dietician	4,067	42,636	10.10	12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	1,892	18,753	9.59	18
19	Laundry				19
20	Administrator	183	7,434	40.62	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)	2,188	52,566	22.85	28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	10,075	99,017	9.75	30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	22,483	22,930	\$ 272,806 *	\$ 11.90 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 \$ 966	L1, C3	35
36	Medical Director	Monthly 7,500	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant	Monthly 2,650	L10, C3	38
39	Pharmacist Consultant	Monthly 564	L10, C3	39
40	Physical Therapy Consultant	Monthly 260	L10a, C3	40
41	Occupational Therapy Consultant	Monthly 488	L10a, C3	41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	Monthly 991	L10a, C3	43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>Dental</u>	Monthly 1,193	L10, C3	46
47	<u>Psychologist</u>	Monthly 2,070	L10, C3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 16,682		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

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

# **0047282**

Report Period Beginning: **1/1/2013**

Ending: **12/31/13**

**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	
Jeremy Maupin	Administrator	100	\$	Workers' Compensation Insurance	\$ 10,109	IDPH License Fee	\$	
Kristi Nottelmann	Other Admin	0	7,434	Unemployment Compensation Insurance	3,700	Advertising: Employee Recruitment	638	
				FICA Taxes	20,804	Health Care Worker Background Check	351	
				Employee Health Insurance	2,336	(Indicate # of checks performed <u>27</u> )		
				Employee Meals	11,542	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Fees	216	
						Clinical Software licensing fees	2,484	
				Allocated from J & J Maupin Enterprises	5,748	Allocated from J & J Maupin Enterprises	30	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 7,434					
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
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 10,400				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 10,400				Seminar Expense	441
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type		Amount				(agree to Sch. V,	
Kelly's Accounting	Accounting		\$ 4,960				line 24, col. 8)	
Templin Healthcare Accounting	Accounting		1,000					
Quickbooks	Payroll Service		96					
Bolen, Robinson, & Ellis, LLP	Legal Services		443					
Duane Morris	Legal Services		871					
Legal Zoom	Legal Documents		30					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 7,400					

\* 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 & ID Number Hickory Point Terrace# 0047282

Report Period Beginning:

1/1/2013

Ending:

12/31/13**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (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. \$ 45,657  
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. \$ 11,542 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 33
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**FACILITY NAME:** Hickory Point Terrace  
**ID #** 0047282

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

**ATTACHED SCHEDULE I**

**SCHEDULE I - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION**

**Care Related Vehicle Expenses:**

<b>Repairs / Maintenance</b>	<b>40</b>
<b>Mileage reimbursement for allowable travel</b>	<b>148</b>
<b>Fuel and miscellaneous supplies</b>	<b>3,388</b>
	<b><u>3,576</u></b>

**FACILITY NAME:** Hickory Point Terrace  
**ID #** 0047282

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

**ATTACHED SCHEDULE II**

**SCHEDULE XX - (12)**

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

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	42,636	1,077	966	44,679	0	44,679	0	44,679
2. Food Purchase	0	23,630	0	23,630	0	23,630	0	23,630
3. Housekeeping	18,753	24,280	0	43,033	0	43,033	0	43,033
4. Laundry	0	145	0	145	0	145	0	145
5. Heat and Other Utilities	0	0	12,861	12,861	0	12,861	0	12,861
6. Maintenance	0	2,934	19,194	22,128	0	22,128	219	22,347
7. Other (specify)*	0	0	1,599	1,599	0	1,599	0	1,599
8. Total General Services	61,389	52,066	34,620	148,075	0	148,075	219	148,294
9. Medical Director	0	0	7,500	7,500	0	7,500	0	7,500
10. Nursing & Medical Records	169,971	7,047	6,575	183,593	0	183,593	0	183,593
10a. Therapy	0	0	1,739	1,739	0	1,739	0	1,739
11. Activities	25,804	8,443	0	34,247	0	34,247	0	34,247
12. Social Services	0	0	0	0	0	0	0	0
13. Nurse Aide Training	8,208	0	0	8,208	0	8,208	0	8,208
14. Program Transportation	0	0	12,917	12,917	0	12,917	-5,422	7,495
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	203,983	15,490	28,731	248,204	0	248,204	-5,422	242,782
17. Administrative	7,434	0	10,400	17,834	0	17,834	9,303	27,137
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	7,400	7,400	0	7,400	328	7,728
20. Fees, Subscriptions & Promotion	0	0	3,689	3,689	0	3,689	30	3,719
21. Clerical & General Office	0	3,931	6,826	10,757	0	10,757	34	10,791
22. Employee Benefits & Payroll	0	0	48,491	48,491	0	48,491	5,748	54,239
23. Inservice Training & Education	0	0	298	298	0	298	0	298
24. Travel and Seminar	0	0	441	441	0	441	0	441
25. Other Admin. Staff Trans	0	0	3,294	3,294	0	3,294	282	3,576
26. Insurance-Prop.Liab.Malpractice	0	0	10,593	10,593	0	10,593	93	10,686
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	7,434	3,931	91,432	102,797	0	102,797	15,818	118,615
29. Total General Administrative	272,806	71,487	154,783	499,076	0	499,076	10,615	509,691
30. Depreciation	0	0	1,518	1,518	0	1,518	14,040	15,558
31. Amortization of Pre-Op. & Org.	0	0	40,000	40,000	0	40,000	-40,000	0
32. Interest	0	0	16,489	16,489	0	16,489	13,654	30,143
33. Real Estate	0	0	6,507	6,507	0	6,507	0	6,507

34. Rent - Facility & Grounds	0	0	97,404	97,404	0	97,404	-36,204	61,200
35. Rent - Equipment & Vehicles	0	0	3,771	3,771	0	3,771	78	3,849
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	165,689	165,689	0	165,689	-48,432	117,257
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	205,645	205,645	0	205,645	0	205,645
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
	42	0	45,657	45,657	0	45,657	0	45,657
43. Other (specify):*	0	0	0	0	0	0	0	0
44. Total Special Cost Ce	0	0	251,302	251,302	0	251,302	0	251,302
45. Grand Total	272,806	71,487	571,774	916,067	0	916,067	-37,817	878,250

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	101,983	101,983
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	2,200	2,200
9. Other (specify):	0	0
10. Total current assets	104,183	104,183
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	0	0
15. Leasehold Improvements, Historical Cost	22,560	21,964
16. Equipment, at Historical Cost	50,392	50,988
17. Accumulated Depreciation (book methods)	-43,951	-43,951
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	204,916	204,916
23. other (specify):	50,000	50,000
24. Total Long-Term Assets	283,917	283,917
25. Total Assets	388,100	388,100
CURRENT LIABILITIES		
26. Accounts Payable	-379	-379
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	13,399	13,399
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	1,358	1,358
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	100,661	100,661

37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	115,039	115,039
LONG TERM LIABILITES		
39. Long-Term Notes Payable	126,620	126,620
40. Mortgage Payable	104,412	104,412
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	-585	-585
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	230,447	230,447
46. Total Liabilities	345,486	345,486
47. Total Equity	42,614	42,614
48. Total Liabilities and Equity	388,100	388,100

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	680,781
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	680,781
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	41,742
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	41,742
24. Contributions	150
25. Interest and Other Investments Income	478
Subtotal - Non-Operating Revenue	628
27. Other Revenue (specify):	205,730
28. Other Revenue (specify):	4,326
Subtotal - Other Revenue	210,056
30. Total Revenue	933,207
31. General Services	148,075
32. Health Care	248,204
33. General Administration	102,797
34. Ownership	165,689

35. Special Cost Centers	205,645
35. Provider Participation Fee	45,657
37. Other	0
40. Total Expenses	916,067
41. Income Before Income Taxes	17,140
42. Income Taxes	0
43. Net Income or Loss for the Year	17,140