



Facility Name & ID Number North Kickapoo

# 0047290 Report Period Beginning: 1/1/16 Ending: 12/31/16

**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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,509			5,509	13
14	TOTALS	5,509			5,509	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 94.07%

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

19 (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 \_\_\_\_\_

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/16 Fiscal Year: 12/31/16

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/16 Ending: 12/31/16

**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	36,325		1,012	37,337		37,337		37,337		1
2	Food Purchase		29,567		29,567		29,567		29,567		2
3	Housekeeping	21,163	14,498		35,661		35,661		35,661		3
4	Laundry										4
5	Heat and Other Utilities			14,312	14,312		14,312		14,312		5
6	Maintenance		3,232	10,052	13,284		13,284	308	13,592		6
7	Other (specify):* <b>Waste Removal</b>			2,625	2,625		2,625		2,625		7
8	<b>TOTAL General Services</b>	57,488	47,297	28,001	132,786		132,786	308	133,094		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	181,576	3,234	5,540	190,350		190,350		190,350		10
10a	Therapy			1,786	1,786		1,786		1,786		10a
11	Activities	16,651	10,328		26,979		26,979		26,979		11
12	Social Services										12
13	CNA Training	6,201			6,201		6,201		6,201		13
14	Program Transportation			7,280	7,280		7,280		7,280		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	204,428	13,562	22,106	240,096		240,096		240,096		16
	<b>C. General Administration</b>										
17	Administrative	24,285		30,300	54,585		54,585	(10,560)	44,025		17
18	Directors Fees										18
19	Professional Services			12,740	12,740		12,740	274	13,014		19
20	Dues, Fees, Subscriptions & Promotions			1,917	1,917		1,917	21	1,938		20
21	Clerical & General Office Expenses		4,525	5,458	9,983		9,983	2,077	12,060		21
22	Employee Benefits & Payroll Taxes			69,372	69,372		69,372	7,471	76,843		22
23	Inservice Training & Education			479	479		479		479		23
24	Travel and Seminar							549	549		24
25	Other Admin. Staff Transportation			1,985	1,985		1,985	13	1,998		25
26	Insurance-Prop.Liab.Malpractice			11,832	11,832		11,832		11,832		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	24,285	4,525	134,083	162,893		162,893	(155)	162,738		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	286,201	65,384	184,190	535,775		535,775	153	535,928		29

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

SEE ACCOUNTANTS' PREPARATION 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:

1/1/16

Ending:

12/31/16

## 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			24,776	24,776		24,776	5,737	30,513			30
31	Amortization of Pre-Op. & Org.			37,083	37,083		37,083	(37,083)				31
32	Interest			18,332	18,332		18,332	11,360	29,692			32
33	Real Estate Taxes			8,404	8,404		8,404	(65)	8,339			33
34	Rent-Facility & Grounds			36,204	36,204		36,204	(36,204)				34
35	Rent-Equipment & Vehicles			10,057	10,057		10,057	(28)	10,029			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			134,856	134,856		134,856	(56,283)	78,573			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			161,489	161,489		161,489		161,489			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			24,351	24,351		24,351		24,351			42
43	Other (specify):* <i>Non-allowable costs</i>											43
44	<b>TOTAL Special Cost Centers</b>			185,840	185,840		185,840		185,840			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	286,201	65,384	504,886	856,471		856,471	(56,130)	800,341			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,479)	30		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	(65)	33		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(417)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(37,083)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (44,044)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(12,086)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (12,086)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (56,130)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

BHF USE ONLY							
48		49		50		51	

North Kickapoo

ID# 0047290

Report Period Beginning: 1/1/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Amortization	\$ (37,083)	31	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(37,083)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning:

1/1/16

Ending:

12/31/16

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	308	0	0	0	0	0	0	0	0	0	308	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	308	0	0	0	0	0	0	0	0	0	308	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	(10,560)	0	0	0	0	0	0	0	0	0	(10,560)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(417)	691	0	0	0	0	0	0	0	0	0	274	19
20	Fees, Subscriptions & Promotions	0	21	0	0	0	0	0	0	0	0	0	21	20
21	Clerical & General Office Expenses	0	2,077	0	0	0	0	0	0	0	0	0	2,077	21
22	Employee Benefits & Payroll Taxes	0	7,471	0	0	0	0	0	0	0	0	0	7,471	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	549	0	0	0	0	0	0	0	0	0	549	24
25	Other Admin. Staff Transportation	0	13	0	0	0	0	0	0	0	0	0	13	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(417)	262	0	0	0	0	0	0	0	0	0	(155)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(417)	570	0	0	0	0	0	0	0	0	0	153	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning:

1/1/16

Ending:

12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(6,479)	12,216	0	0	0	0	0	0	0	0	0	5,737	30
31	Amortization of Pre-Op. & Org.	(37,083)	0	0	0	0	0	0	0	0	0	0	(37,083)	31
32	Interest	0	11,360	0	0	0	0	0	0	0	0	0	11,360	32
33	Real Estate Taxes	(65)	0	0	0	0	0	0	0	0	0	0	(65)	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	(28)	0	0	0	0	0	0	0	0	0	(28)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(43,627)</b>	<b>(12,656)</b>	<b>0</b>	<b>(56,283)</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>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(44,044)</b>	<b>(12,086)</b>	<b>0</b>	<b>(56,130)</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
<u>Jeremy Maupin</u>	<u>100</u>	<u>J&amp;J Maupin Homes Hickory Point Terrace</u>	<u>Forsyth</u>	<u>J&amp;J Maupin Enterpris</u>	<u>Decatur, IL</u>	<u>Real Estate</u>
		<u>Joe Jac Spring Creek Terrace</u>	<u>Decatur</u>	<u>A Step Forward</u>	<u>Decatur, IL</u>	<u>Day Training &amp; 3 CILAs</u>

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>6 Maintenance</u>	\$	<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	\$ <u>308</u>	\$ <u>308</u>	<u>1</u>
2	V	<u>17 Administrative</u>	<u>30,300</u>	<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>19,740</u>	<u>(10,560)</u>	<u>2</u>
3	V	<u>19 Professional Fees</u>		<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>691</u>	<u>691</u>	<u>3</u>
4	V	<u>20 Dues, Subscriptions, Licenses</u>		<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>21</u>	<u>21</u>	<u>4</u>
5	V	<u>21 Office Supplies &amp; Expense</u>		<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>2,077</u>	<u>2,077</u>	<u>5</u>
6	V	<u>22 Employee Benefits</u>		<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>7,471</u>	<u>7,471</u>	<u>6</u>
7	V	<u>24 Travel &amp; Seminar</u>		<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>549</u>	<u>549</u>	<u>7</u>
8	V	<u>25 Other Admin Staff Trans</u>		<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>13</u>	<u>13</u>	<u>8</u>
9	V	<u>30 Depreciation</u>		<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>12,216</u>	<u>12,216</u>	<u>9</u>
10	V	<u>32 Interest</u>		<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>11,360</u>	<u>11,360</u>	<u>10</u>
11	V	<u>35 Rent Exp</u>	<u>1,050</u>	<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>	<u>1,022</u>	<u>(28)</u>	<u>11</u>
12	V	<u>34 Rent Facility</u>	<u>36,204</u>	<u>J&amp;J Maupin Enterprises</u>	<u>100.00%</u>		<u>(36,204)</u>	<u>12</u>
13	V							<u>13</u>
14	Total		\$ <u>67,554</u>			\$ <u>55,468</u>	\$ * <u>(12,086)</u>	<u>14</u>

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo # 0047290 Report Period Beginning: 1/1/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeremy Maupin	President	Administrative	100.00	74,660	15	25.00	Salary	\$ 19,740	L17, C 7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,740		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' PREPARATION REPORT

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning:

1/1/16

Ending: 12/31/16

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

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

Name of Related Organization J&J Maupin Enterprises  
 Street Address 5310 E. William Street Road  
 City / State / Zip Code Decatur, IL 62521  
 Phone Number ( 217-422-6361  
 Fax Number ( 217-422-6365

1	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	4,330,603	4	\$ 1,472	\$ 905,589	\$ 308	1
2	17	Administrative	Revenue	4,330,603	4	94,400	94,400	19,740	2
3	19	Professional Fees	Revenue	4,330,603	4	3,308	905,589	691	3
4	20	Dues, Subscriptions, Licenses	Revenue	4,330,603	4	100	905,589	21	4
5	21	Office Supplies & Expense	Revenue	4,330,603	4	9,931	905,589	2,077	5
6	22	Employee Benefits	Revenue	4,330,603	4	35,725	905,589	7,471	6
7	24	Travel & Seminar	Revenue	4,330,603	4	2,627	905,589	549	7
8	25	Other Admin Staff Trans	Revenue	4,330,603	4	61	905,589	13	8
9	30	Depreciation	Revenue	4,330,603	4	58,416	905,589	12,216	9
10	32	Interest	Revenue	4,330,603	4	54,325	905,589	11,360	10
11	35	Rent Exp	Revenue	4,330,603	4	4,888	905,589	1,022	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					\$ 265,253	\$ 94,400	\$ 55,468	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning:

1/1/16

Ending:

12/31/16

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	First Mid IL Bank & Trust		X	Facility	\$3,388.74	10/26/05	\$ 366,667	\$	9/26/2015	4.2500	\$ 1,753	1								
2												2								
3												3								
4	RBS Citizens Bank		X	Auto Loan	\$394.92	11/14/14	22,124	10,208	11/14/19	2.1400	380	4								
5	Soy Capital		X	Auto Loan	\$440.52	8/1/16	25,371	22,865	7/1/2021	3.2400	256	5								
<b>Working Capital</b>																				
6	First Mid IL Bank & Trust		X	Line of Credit		9/26/09				6.0000	14,826	6								
7	Kim Robinson		X	Working Capital	\$1,130.44	9/16/05	170,000	69,067	8/16/2015	6.5000		7								
8	Heartland Bank & Trust		X	Line of Credit		11/10/16		26,000	11/10/17	4.5000	1,025	8								
9	TOTAL Facility Related				\$5,354.62		\$ 584,162	\$ 128,140			\$ 18,240	9								
<b>B. Non-Facility Related*</b>																				
10											92	10								
11											11,360	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 11,452	14								
15	TOTALS (line 9+line14)						\$ 584,162	\$ 128,140			\$ 29,692	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.)

SEE ACCOUNTANTS' PREPARATION REPORT

\*\* 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**

**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 2015 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.)	2015	\$	<b>8,339</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>8,339</b>	3
4. Real Estate Tax accrual used for 2016 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.		\$	<b>8,339</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<b>10,904</b>	8
	2012	<b>8,212</b>	9
	2013	<b>8,386</b>	10
	2014	<b>8,248</b>	11
	2015	<b>8,339</b>	12

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2015	\$		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' PREPARATION REPORT

**2015 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 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>08-029-015-50</u>	<u>Facility</u>	\$ <u>8,339.12</u>	\$ <u>8,339.12</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>8,339.12</u></u>	\$ <u><u>8,339.12</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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number North Kickapoo

# 0047290 Report Period Beginning:

1/1/16 Ending:

12/31/16

X. BUILDING AND GENERAL INFORMATION:

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

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

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

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.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, 2, 3, \$, 1. Row 2: 2, 2. Row 3: 3 TOTALS, \$, 3.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning:

1/1/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Parking Lot		2009	500		15	33	33	216	9
10	Carpeting - 2 living rooms, bedrooms 4 & 5		2013	1,934		10	193	193	676	10
11	Flooring-Men's End Living Room		2015	1,300		10	130	130	195	11
12	New Kitchen Countertops		2015	1,508		10	151	151	226	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20	Financial Statement basis depreciation				24,776			(24,776)		20
21										21
22										22
23	Allocated from J & J Maupin Enterprises						12,216	12,216		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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning:

1/1/16

Ending:

12/31/16

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)	\$ 5,242	\$ 24,776		\$ 12,723	\$ (12,053)	\$ 1,313	70

SEE ACCOUNTANTS' PREPARATION 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:

1/1/16

Ending:

12/31/16

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	\$ 98,791	\$	\$ 9,879	\$ 9,879	5-10 yrs	\$ 70,458	71
72	Current Year Purchases	9,739		487	487	10	487	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 108,530	\$	\$ 10,366	\$ 10,366		\$ 70,945	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Program Transportation	2002 Dodge Caravan	2005	\$ 2,500	\$	\$	\$	5 yr	\$ 2,500	76
77	Program Transportation	2006 Dodge Caravan	2007	18,523				5 yr	18,523	77
78	Program Transportation	2014 Ford Transit	2014	24,433		4,887	4,887	5 yr	10,181	78
79	Program Transportation	2013 Honda Van	2016	25,371		2,537	2,537	5 yr	2,537	79
80	TOTALS			\$ 70,827	\$	\$ 7,424	\$ 7,424		\$ 33,741	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)	\$ 184,599	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,776	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,513	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,737	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 105,999	85

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

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

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6					_____			6
7	<b>TOTAL</b>				\$ _____			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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: \$ 1,022 Description: Office equipment

(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>2014 Honda Oddesey</u>	<u>501.55</u>	<u>6,019</u>	17
18	<u>Resident</u>	<u>2014 Dodge XST Van</u>	<u>426.98</u>	<u>2,988</u>	18
19					19
20					20
21	<b>TOTAL</b>		\$ <u>928.53</u>	\$ <u>9,007</u>	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' PREPARATION REPORT

**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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)		6,201		6,201
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$ 6,201	\$	\$ 6,201
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$	6,201		

**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	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>3</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.
- SEE ACCOUNTANTS' PREPARATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Day Training</u>	<u>39(3)</u>				<u>161,489</u>			<u>161,489</u>	13
14	TOTAL			\$		\$ <u>161,489</u>	\$		\$ <u>161,489</u>	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning: 1/1/16

Ending:

12/31/16

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/16

(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	\$ 27,670	\$ 27,670	1
2	Cash-Patient Deposits	2,100	2,100	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	72,919	72,919	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	170	170	7
8	Accounts Receivable (owners or related parties)	56,841	56,841	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 159,700	\$ 159,700	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	2,008	5,242	15
16	Equipment, at Historical Cost	182,591	179,357	16
17	Accumulated Depreciation (book methods)	(145,081)	(105,999)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Goodwill</u> )	126,580	126,580	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 166,098	\$ 205,180	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 325,798	\$ 364,880	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 21,458	\$ 21,458	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 21,458	\$ 21,458	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	128,140	128,140	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 128,140	\$ 128,140	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 149,598	\$ 149,598	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 176,200	\$ 215,282	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 325,798	\$ 364,880	48

SEE ACCOUNTANTS' PREPARATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>268,588</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment - Income / Day Training adjs</b>	(116,261)	<b>3</b>
<b>4</b>	<b>Prior Period Adjustment - Maint Exp reversal</b>	392	<b>4</b>
<b>5</b>	<b>Prior Period Adjustment - Reclassify Draws</b>	1,095	<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>153,814</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	49,118	<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	(26,732)	<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>22,386</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>176,200</b>	<b>24</b> *

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

SEE ACCOUNTANTS' PREPARATION REPORT

**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	\$ 700,053	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 700,053	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	41,375	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>	\$ 41,375	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Workshop Revenue</u>	161,746	28
28a	<u>EIC \$1,535; Transportation charges \$880</u>	2,415	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 164,161	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 905,589	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	132,786	31
32	Health Care	240,096	32
33	General Administration	162,893	33
<b>B. Capital Expense</b>			
34	Ownership	134,856	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	161,489	35
36	Provider Participation Fee	24,351	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 856,471	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	49,118	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 49,118	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 700,053	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>	\$ 700,053	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number North Kickapoo

# 0047290

Report Period Beginning:

1/1/16

Ending:

12/31/16

**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	639	719	19,891	27.66
4	Licensed Practical Nurses				4
5	CNAs & Orderlies				5
6	CNA Trainees	644	644	6,201	9.63
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,667	1,699	16,651	9.80
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician	2,970	3,146	36,325	11.55
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers	1,704	2,016	21,163	10.50
19	Laundry				19
20	Administrator	520	520	24,285	46.70
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)	1,928	2,080	45,157	21.71
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)	11,608	11,983	116,528	9.72
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	21,680	22,807	\$ 286,201 *	\$ 12.55

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 1,012	L1, C3
36	Medical Director	Monthly	7,500	L9, C3
37	Medical Records Consultant			
38	Nurse Consultant	Monthly	2,200	L10, C3
39	Pharmacist Consultant	Monthly	168	L10, C3
40	Physical Therapy Consultant	Monthly	487	L10a, C3
41	Occupational Therapy Consultant	Monthly	487	L10a, C3
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant	Monthly	812	L10a, C3
44	Activity Consultant			
45	Social Service Consultant			
46	Other(specify) <u>Dental</u>	Monthly	1,172	L10, C3
47	<u>Psychologist</u>	Monthly	2,000	L10, C3
48				
49	TOTAL (lines 35 - 48)		\$ 15,838	

**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

SEE ACCOUNTANTS' PREPARATION REPORT

**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	
Kristi Nottelmann	Administrator	0	\$ 24,285	Workers' Compensation Insurance	\$ 8,883	IDPH License Fee	\$	
				Unemployment Compensation Insurance	3,648	Advertising: Employee Recruitment	1,031	
				FICA Taxes	19,174	Health Care Worker Background Check (Indicate # of checks performed )		
				Employee Health Insurance	22,782	Patient Background Checks	1 35	
				Employee Meals	14,885	Licenses and Fees	851	
				Illinois Municipal Retirement Fund (IMRF)*		Allocated from J & J Maupin Enterprises	21	
				Allocated from J & J Maupin Enterprises	7,471	Less: Public Relations Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 24,285			Non-allowable advertising	( )	
						Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 76,843	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 1,938	
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			\$ 30,300	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Allocated from J & J Maupin Enterprises	549
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 30,300				Entertainment Expense	( )
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount					
Kelly's Accounting	Accounting		\$ 1,059					
Templin Healthcare Accounting	Accounting		1,050					
McGuire, Yuhas, Huffman, Buckley,	Accounting		6,056					
Bolen, Robinson, & Ellis, LLP	Legal Services		4,575					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 12,740					

\* Attach copy of IMRF notifications  
 SEE ACCOUNTANTS' PREPARATION REPORT

\*\*See instructions.

Facility Name & ID Number North Kickapoo# 0047290

Report Period Beginning:

1/1/16

Ending:

12/31/16**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. N/A
- (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 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 24,351  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 14,885 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? 79  
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: \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees

**SEE ACCOUNTANTS' PREPARATION REPORT**

**North Kickapoo**

**Period Beginning**      **1/1/16**  
**Period End**            **12/31/16**

**ATTACHED SCHEDULE**

**SCHEDULE XX - (12)**

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