FOR BHF USE

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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

I. IDPH License ID Number: 0048694

Facility Name: Hope Creek Care Center

Address: 4343 Kennedy Drive (Number) East Moline (City) 61244 (Zip Code)

County: Rock Island

Telephone Number: (309) 796-6600 **Fax #** (309) 796-6001

HFS ID Number:

Date of Initial License for Current Owners: 9/1/1972

Type of Ownership:

- [ ] VOLUNTARY,NON-PROFIT
  - [ ] Charitable Corp.
  - [ ] Trust
- [ ] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [X] GOVERNMENTAL
  - [ ] State
  - [X] County
  - [ ] Other

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2014 to 11/30/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) RSM US LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,353	4,574	8,095	26,022	8
9	SNF/PED					9
10	ICF	28,644	19,543	2,901	51,088	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,997	24,117	10,996	77,110	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.23%

D. How many bed-hold days during this year were paid by the Department?
N/A (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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/1/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 245 and days of care provided 6,720

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 11/30/15 Fiscal Year: 11/30/15

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	765,530	72,224	23,938	861,692		861,692		861,692			1
2	Food Purchase		544,009		544,009		544,009		544,009			2
3	Housekeeping	298,583	74,060	4,270	376,913		376,913		376,913			3
4	Laundry	294,076	22,962		317,038		317,038		317,038			4
5	Heat and Other Utilities			281,954	281,954		281,954		281,954			5
6	Maintenance	217,450	66,829	275,443	559,722		559,722	(2,645)	557,077			6
7	Other (specify):*											7
8	TOTAL General Services	1,575,639	780,084	585,605	2,941,328		2,941,328	(2,645)	2,938,683			8
	B. Health Care and Programs											
9	Medical Director							25,000	25,000			9
10	Nursing and Medical Records	5,638,703	303,217	665,440	6,607,360		6,607,360	(30,446)	6,576,914			10
10a	Therapy	150,898			150,898		150,898		150,898			10a
11	Activities	348,322	6,032	907	355,261		355,261		355,261			11
12	Social Services	187,309	33	62	187,404		187,404		187,404			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	6,325,232	309,282	666,409	7,300,923		7,300,923	(5,446)	7,295,477			16
	C. General Administration											
17	Administrative							68,219	68,219			17
18	Directors Fees							12,326	12,326			18
19	Professional Services							445,121	445,121			19
20	Dues, Fees, Subscriptions & Promotions			16,938	16,938		16,938		16,938			20
21	Clerical & General Office Expenses	329,387	17,130	536,598	883,115		883,115	(222,667)	660,448			21
22	Employee Benefits & Payroll Taxes			3,174,329	3,174,329		3,174,329	81,237	3,255,566			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,099	3,099		3,099		3,099			24
25	Other Admin. Staff Transportation			5,620	5,620		5,620	(151)	5,469			25
26	Insurance-Prop.Liab.Malpractice			18,590	18,590		18,590		18,590			26
27	Other (specify):*											27
28	TOTAL General Administration	329,387	17,130	3,755,174	4,101,691		4,101,691	384,085	4,485,776			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	8,230,258	1,106,496	5,007,188	14,343,942		14,343,942	375,994	14,719,936			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Hope Creek Care Center #0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							573,444	573,444			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			637,032	637,032		637,032	(3,656)	633,376			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							208	208			34
35	Rent-Equipment & Vehicles			31,219	31,219		31,219		31,219			35
36	Other (specify):*											36
37	**TOTAL Ownership**			668,251	668,251		668,251	569,996	1,238,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		414,641	1,007,165	1,421,806		1,421,806		1,421,806			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							561,405	561,405			42
43	Other (specify):* Non-Allowable Cos		6,127	1,043,246	1,049,373		1,049,373	(1,049,373)				43
44	**TOTAL Special Cost Centers**		420,768	2,050,411	2,471,179		2,471,179	(487,968)	1,983,211			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	8,230,258	1,527,264	7,725,850	17,483,372		17,483,372	458,022	17,941,394			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 Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(22,434)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(13,262)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	573,444	30		9
10	Interest and Other Investment Income	(3,656)	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	(509,962)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 24,130		$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	433,892		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 433,892		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 458,022		37

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

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

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

STATE OF ILLINOIS **Page 5A**

Hope Creek Care Center

ID# 0048694

Report Period Beginning: 12/1/2014

Ending: 11/30/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (20,189)	43	1
2	Principal	(1,000,000)	43	2
3	Professional Services	(248)	43	3
4	Diagnostics	(300)	43	4
5	Reclass Provider Bed Tax	561,405	42	5
6	Miscellaneous Income	(49)	21	6
7	Unsupported Travel Expense	(151)	25	7
8	Operating Supplies	(261)	43	8
9	Small Tools & Equip under $1,000	(106)	43	9
10	Publishing	(250)	43	10
11	Food Purchases	(1,061)	43	11
12	Operating Supplies	(4,449)	43	12
13	Dues & Memberships	(75)	43	13
14	Offset Admission Coordinator	(41,583)	21	14
15	Capitalize Repairs and Maintenance	(2,645)	6	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(509,962)		49

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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
Rock Island County	100	Oak Glen Home	Coal Valley	N/A		

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Welfare Committee	$	Rock Island County	100.00%	$ 12,326	$ 12,326	1
2	V	19	Risk Management		Rock Island County	100.00%	212,214	212,214	2
3	V	19	General Management		Rock Island County	100.00%	10,530	10,530	3
4	V	19	Auditor		Rock Island County	100.00%	23,744	23,744	4
5	V	19	Information Systems		Rock Island County	100.00%	48,002	48,002	5
6	V	19	Treasurer		Rock Island County	100.00%	320	320	6
7	V	19	County Board		Rock Island County	100.00%	45,311	45,311	7
8	V	22	Worker's Comp		Rock Island County	100.00%	81,237	81,237	8
9	V	34	County Buildings		Rock Island County	100.00%	208	208	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 433,892	$ * 433,892	14

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STEVE MEERSMAN	CHAIR, NUR HM C	DIRECTOR	0.00	0	1	2.00	Salary	$ 3,582	18(7)	1
2	KIM CALLWAY-THOMPSO	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	Salary	1,457	18(7)	2
3	DON JOHNSTON	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	Salary	1,457	18(7)	3
4	RON OELKE	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	Salary	1,457	18(7)	4
5	BRIAN VYNCKE	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	Salary	1,457	18(7)	5
6	ED LANGDON	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	Salary	1,457	18(7)	6
7	PAT MORENO	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	Salary	1,457	18(7)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 12,326		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 Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 1/30/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: ROCK ISLAND COUNTY
Street Address: 11210 95TH STREET
City / State / Zip Code: COAL VALLEY, IL 61240
Phone Number: (309) 558-3585
Fax Number: (309) 558-3516

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Welfare Committee	Cost Allocation Study	100		$ 12,326	$ 12,326	100	$ 12,326	1
2	19	Risk Management	Cost Allocation Study	100		212,214		100	212,214	2
3	19	General Management	Cost Allocation Study	100		10,530		100	10,530	3
4	19	Auditor	Cost Allocation Study	100		23,744		100	23,744	4
5	19	Information Systems	Cost Allocation Study	100		48,002		100	48,002	5
6	19	Treasurer	Cost Allocation Study	100		320		100	320	6
7	19	County Board	Cost Allocation Study	100		45,311		100	45,311	7
8	22	Worker's Comp	Cost Allocation Study	100		81,237		100	81,237	8
9	34	County Buildings	Cost Allocation Study	100		208		100	208	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 433,892	$ 12,326		$ 433,892	25

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bond (2006 Series)		X	Capital Expenditures	Semi-Annual	12/29/06	$ 9,950,000	$ 5,635,000	6/1/2027	0.0360	$ 223,107	1
2	Bond (2007 Series)		X	Capital Expenditures	Semi-Annual	4/4/07	9,935,000	6,220,000	11/30/2028	0.0400	318,508	2
3	Bond (2013 Series)		X	Capital Expenditures	Semi-Annual	5/9/2013	3,700,000	3,515,000	12/1/2024	0.0200	95,417	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 23,585,000	$ 15,370,000			$ 637,032	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(3,656)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,656)	14
15	TOTALS (line 9+line14)						$ 23,585,000	$ 15,370,000			$ 633,376	15

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

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

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	**2014**	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	**Allocated from Managment Co.**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010		8
	2011		9
	2012	N/A	10
	2013		11
	2014		12

County Facility

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hope Creek Care Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0048694

CONTACT PERSON REGARDING THIS REPORT Trudy Whittington

TELEPHONE (309) 796-6600 FAX #: (309) 799-5904

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

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	County facility exempt from RE tax		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

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 N/A 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 120,731 B. General Construction Type: Exterior Brick Frame Block & Brick Number of Stories Two

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Non-Facility	280	1917	$ 18,526	1
2	Facility		2006	1,598,000	2
3	TOTALS	280		$ 1,616,526	3

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		2009	2009	$ 19,711,553	$	40	$ 492,764	$ 492,764	$ 3,202,978	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Front Lawn Landscaping			2009	4,983		10	498	498	3,237	9
10	Parking Lots			2009	215,420		30	7,181	7,181	46,676	10
11											11
12	Time Clock			2010	13,500		15	900	900	4,950	12
13											13
14	Trane Furnace & AC in HCC Annex Bldg			2014	6,724		10	672	672	1,008	14
15											15
16	Picnic Pavilion			2015	157,830		20	3,946	3,946	3,946	16
17	2 Thermostats - Rooftop Unit 12 on Building 5			2015	2,645		10	132	132	132	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

**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 Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 20,112,655	$		$ 506,093	$ 506,093	$ 3,262,927	70

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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	$ 753,088	$	$ 65,539	$ 65,539	10	$ 375,374	71
72	Current Year Purchases	6,193		310	310	10	310	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 759,281	$	$ 65,849	$ 65,849		$ 375,684	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	Patient Care	Ford, Diesel Bus, 1994	1994	$ 44,742	$	$	$	5	$ 44,742	76
77	Patient Care	Chevy Pick-Up, 1993	1993	13,527				5	13,527	77
78	Patient Care	Chevy, Truck, 2002	2001	26,111				5	26,111	78
79	Patient Care	Various (See SCH 13A)		70,302		1,502	1,502	5	70,302	79
80	TOTALS			$ 154,682	$	$ 1,502	$ 1,502		$ 154,682	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)	$ 22,643,144	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 573,444	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 573,444	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,793,293	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	Building - 1948	$ 8,412	$	$	86
87	Building - 1950	5,174			87
88	Building - 1954	339,336			88
89	Building - 1967	535,870			89
90	Vehicles - 2002 & 2010	28,523			90
91	TOTALS	$ 917,315	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2015**

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Patient Care	Chevy, Minivar	2003	33,295			-	5	33,295
Patient Care	Chrysler Town	2007	21,991			-	5	21,991
Patient Care	Ford Fusion, 20	2010	15,016		1,502	1,502	5	15,016
						-		
TOTAL			**70,302**	**-**	**1,502**	**1,502**		**70,302**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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		County Buildings			208.00			6
7	TOTAL				$ 208 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 31,219 Description: Nursing Equip $25,438 (Oxygen & Concentrator); Wound Care $ 4,868, Booth Rental $913
    (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	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3	hrs	$	4,358	$ 383,675	$	4,358	$ 383,675	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		2,955	244,303		2,955	244,303	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		5,097	379,187		5,097	379,187	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				386,435		386,435	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					28,206		28,206	12
13	Other (specify):									13
14	TOTAL			$	12,410	$ 1,007,165	$ 414,641	12,410	$ 1,421,806	14

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

STATE OF ILLINOIS

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 44,078	$ 44,078	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (2,040,024))	1,972,820	1,972,820	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	233,000	233,000	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,480	1,480	7
8	Accounts Receivable (owners or related parties)	1,135,310	1,135,310	8
9	Other(specify): Due Form Other Govt. Unit	38,203	38,203	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,424,891	$ 3,424,891	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,616,526	13
14	Buildings, at Historical Cost		19,711,553	14
15	Leasehold Improvements, at Historical Cost		401,102	15
16	Equipment, at Historical Cost		913,963	16
17	Accumulated Depreciation (book methods)		(3,793,293)	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			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 18,849,851	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,424,891	$ 22,274,742	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 768,168	$ 768,168	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,887	229,887	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
	Other Current Liabilities(specify):			
36	See Sch 17A	2,632,920	2,632,920	36
37	See Sch 17A	3,717	3,717	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,634,692	$ 3,634,692	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		15,370,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 15,370,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,634,692	$ 19,004,692	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (209,801)	$ 3,270,050	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,424,891	$ 22,274,742	48

*(See instructions.)

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2015**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Due Other Funds	396,850	396,850
Due other funds - transfers	356,632	356,632
Deferred Revenue	1,879,438	1,879,438
Total - Line 36	**2,632,920**	**2,632,920**

XV. Balance Sheet
Line 37 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Deposits	400	400
Unclaimed Voucher Checks	2,911	2,911
Unclaimed Payroll Checks	406	406
Total - Line 37	**3,717**	**3,717**

Facility Name & ID Number Hope Creek Care Center **#** 0048694 **Report Period Beginning:** 12/1/2014 **Ending:** 11/30/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 503,717	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 503,717	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(713,517)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **ROUNDING**	(1)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (713,518)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (209,801)	24	*

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,043,443	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,043,443	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	151,711	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 151,711	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	27,149	15
16	Rental of Facility Space	1,125	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	13,262	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	12,730	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 54,266	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,656	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,656	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See Sch 19A	2,516,779	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,516,779	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,769,855	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,941,328	31
32	Health Care	7,300,923	32
33	General Administration	4,101,691	33
	B. Capital Expense		
34	Ownership	668,251	34
	C. Ancillary Expense		
35	Special Cost Centers	2,471,179	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 17,483,372	40
41	**Income before Income Taxes (line 30 minus line 40)****	(713,517)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (713,517)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,396,679	44
45	Private Pay - Net Inpatient Revenue	482,020	45
46	Medicare - Net Inpatient Revenue	2,608,920	46
47	Other-(specify) Patient Fees	4,588,020	47
48	Other-(specify) See Sch 19C	1,967,804	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,043,443	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ 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.**

^ - This entity is a government entity

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2015**

Schedule 19A

XVII. Income Statement
Line 28 Other Revenue (specify):

Description	Amount
IGT- Inter governmental transfer funds	615,930
Transportation charge	4,418
Refunds/rebates for prior years	38
Miscellaneous - other revenue	49
Transfer from nurse home taxlevy	2,269,715
Transfer from IMRF Fund	811,423
Transfer from FICA Fund	610,256
Transfer to General Fund	(481,987)
Transfer unpaid prior yr admin fees to General	(621,412)
Transfer unpaid prior yr admin fees to Liability	(124,000)
Transfer to Liability Insurance	(62,000)
Transfer to Other Agencies	(593,654)
Transfer of Medicare cost overpayment prior yr	(27,241)
State grants - social services	115,244
Total - Line 28	**2,516,779**

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2015**

Schedule 19C

XVII. Income Statement
Line 48 Net Inpatient Revenue detailed by Payer Source Other (specify):

Description	Amount
I P A resident fees	1,732,533
VA Revenues	235,271
Total - Line 48	**1,967,804**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,087	1,353	$ 46,571	$ 34.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	20,667	23,942	542,009	22.64	3
4	Licensed Practical Nurses	74,009	81,816	1,572,612	19.22	4
5	CNAs & Orderlies	210,042	230,445	3,340,334	14.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,263	8,816	150,898	17.12	8
9	Activity Director	3,184	3,360	64,329	19.15	9
10	Activity Assistants	19,712	21,343	283,993	13.31	10
11	Social Service Workers	8,134	9,989	187,309	18.75	11
12	Dietician					12
13	Food Service Supervisor	2,828	3,577	75,517	21.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	45,801	50,632	690,014	13.63	15
16	Dishwashers					16
17	Maintenance Workers	8,861	10,226	217,450	21.26	17
18	Housekeepers	20,118	22,249	298,583	13.42	18
19	Laundry	16,517	19,684	294,076	14.94	19
20	Administrator	1,328	1,873	68,219	36.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,824	11,925	219,585	18.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health CSee Sch 20A	5,888	6,927	137,177	19.80	32
33	Other(specify) Admissions Coord	1,899	2,202	41,583	18.88	33
34	TOTAL (lines 1 - 33)	457,162	510,360	$ 8,230,258 *	$ 16.13	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 23,938	1(3)	35
36	Medical Director	Monthly	25,000	9(7)	36
37	Medical Records Consultant	Monthly	6,657	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,905	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	907	11(3)	44
45	Social Service Consultant	Monthly	62	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 66,469		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,810	$ 76,174	10(3)	50
51	Licensed Practical Nurses	3,769	127,455	10(3)	51
52	Certified Nurse Assistants/Aides	18,758	428,065	10(3)	52
53	TOTAL (lines 50 - 52)	24,337	$ 631,694		53

Facility Name: **Tabor Hills Health Care Facility, Inc.**
IDPH License ID Number: **0040543**
Fiscal Year End: **1/0/1900**

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32 Other Health Care (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Central Supply Clerk	2,664	3,407	63,373	$ 18.60
Memory Care Coordinator	3,223	3,519	73,804	$ 20.97
Total - Line 32 Other Health Care (specify):	**5,888**	**6,927**	**137,177**	**$ 19.80**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trudy Whittington	Administrator	0%	$
See Schedule 21A			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21C	Various	$ 0
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 81,237
Unemployment Compensation Insurance	
FICA Taxes	610,256
Employee Health Insurance	1,665,052
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	831,443
Uniform Clothing	47,970
Other Employee Benefits	19,608
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,255,566

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 30)	910
Patient Background Checks 349	3,490
Publishing	9,123
Miscellaneous Dues & Subscriptions	3,415
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,938

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,099
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,099

**See instructions.

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2014**

Schedule 21A

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership	Amount
Administrator Salaries from Schedule XIX Section A			0
Trudy Whittington-Reclassed from Line 21	Administrator	0	68,219
	Total (agree to Schedule V, line 17, column 7)		68,219

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2015**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Professional Fees from Schedule XIX Section C		
	Total (agree to Schedule V, line 19, column 3)	-
Gabelmann & Associates	Accounting	100,000
RSM US LLP	Accounting	5,000
	Allocated from County Auditor	23,744
	Allocated from County County Board	45,311
	Allocated from County General Management	10,530
	Allocated from County Information Systems	48,002
	Allocated from County Risk Management	212,214
	Allocated from County Treasurer	320
	Total (agree to Schedule V, line 19, column 8)	445,121

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2014 Ending: 11/30/2015

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													N/A
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Hope Creek Care Center # 0048694 **Report Period Beginning:** 12/1/2014 **Ending:** 11/30/2015

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(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. $ **55,686** 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. $ **561,405**
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? **No** 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. $ **N/A** Has any meal income been offset against related costs? **N/A** 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? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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? **Yes**
Firm Name: **RSM US LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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. **No**
Attach invoices and a summary of services for all architect and appraisal fees.