



Facility Name & ID Number Hope Creek Care Center

# 0048694 Report Period Beginning: 12/1/09 Ending: 11/30/10

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	8,479	2,486	9,470	20,435	8	
9	SNF/PED					9	
10	ICF	47,115	18,710	245	66,070	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	55,594	21,196	9,715	86,505	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.73%

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

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES  NO

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

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

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

YES  NO  If YES, enter number of beds certified 20 and days of care provided 9,470

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 11/30/09 Fiscal Year: 11/30/09

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/09 Ending: 11/30/10

**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	719,302	77,942	22,593	819,837		819,837		819,837		1
2	Food Purchase		569,480		569,480		569,480		569,480		2
3	Housekeeping	405,262	59,546	6,055	470,863		470,863		470,863		3
4	Laundry	263,153	39,321		302,474		302,474		302,474		4
5	Heat and Other Utilities			283,787	283,787		283,787		283,787		5
6	Maintenance	271,228	71,633	78,087	420,948		420,948		420,948		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,658,945	817,922	390,522	2,867,389		2,867,389		2,867,389		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			27,987	27,987		27,987		27,987		9
10	Nursing and Medical Records	5,539,295	14,626	321,422	5,875,343		5,875,343		5,875,343		10
10a	Therapy	120,027	2,740	1,162,228	1,284,995		1,284,995		1,284,995		10a
11	Activities	300,441		760	301,201		301,201		301,201		11
12	Social Services	120,361	7,195		127,556		127,556		127,556		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	6,080,124	24,561	1,512,397	7,617,082		7,617,082		7,617,082		16
	<b>C. General Administration</b>										
17	Administrative	102,676			102,676		102,676		102,676		17
18	Directors Fees							10,246	10,246		18
19	Professional Services							397,744	397,744		19
20	Dues, Fees, Subscriptions & Promotions			14,023	14,023		14,023		14,023		20
21	Clerical & General Office Expenses	173,954	17,108	58,539	249,601		249,601	3,631	253,232		21
22	Employee Benefits & Payroll Taxes			2,714,060	2,714,060		2,714,060	63,361	2,777,421		22
23	Inservice Training & Education										23
24	Travel and Seminar			14,217	14,217		14,217	(4,324)	9,893		24
25	Other Admin. Staff Transportation			7,645	7,645		7,645		7,645		25
26	Insurance-Prop.Liab.Malpractice			23,184	23,184		23,184		23,184		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	276,630	17,108	2,831,668	3,125,406		3,125,406	470,658	3,596,064		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	8,015,699	859,591	4,734,587	13,609,877		13,609,877	470,658	14,080,535		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Hope Creek Care Center

#0048694

Report Period Beginning:

12/1/09

Ending:

11/30/10

## 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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			28,139	28,139		28,139	535,883	564,022			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			614,401	614,401		614,401	64,055	678,456			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							849	849			34
35	Rent-Equipment & Vehicles			13,764	13,764		13,764		13,764			35
36	Other (specify):* Donated Goods							6,183	6,183			36
37	<b>TOTAL Ownership</b>			656,304	656,304		656,304	606,970	1,263,274			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		656,219	2,948	659,167		659,167		659,167			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,138	134,138		134,138		134,138			42
43	Other (specify):* Non-Allowable Cos		3,258	1,934,117	1,937,375		1,937,375	(1,937,375)				43
44	<b>TOTAL Special Cost Centers</b>		659,477	2,071,203	2,730,680		2,730,680	(1,937,375)	793,305			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,015,699	1,519,068	7,462,094	16,996,861		16,996,861	(859,747)	16,137,114			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center

# 0048694

Report Period Beginning:

12/1/09

Ending:

11/30/10

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	(29,398)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	535,883	30		9
10	Interest and Other Investment Income	64,055	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	(2,492)	43		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 Pg 5A	(1,906,178)	Var.		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (1,338,130)		\$	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*	6,183	36	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	472,200		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 478,383		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (859,747)		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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Hope Creek Care Center

ID# 0048694

Report Period Beginning: 12/1/09

Ending: 11/30/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (48,639)	43	1
2	X-Rays - Part A	(3,968)	43	2
3	Offset Transfers to Other Funds	(834,724)	43	3
4	Transfer to Liability Insurance	(51,677)	43	4
5	Transfer to Capital Projects Fund	(500,000)	43	5
6	Un-supported Travel & Seminar Exp	(4,324)	24	6
7	Bank service fees	(1,045)	43	7
8	Office supplies	(8)	43	8
9	Operating Supplies	(758)	43	9
10	Professional Services	(41,849)	43	10
11	Printing	(9)	43	11
12	Diagnostic	(2,880)	43	12
13	Outside Contractual	(9,925)	43	13
14	Miscellaneous	(3)	43	14
15	Principle Retirement	(410,000)	43	15
16	Misc. Income	3,631	21	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>	(1,906,178)		49

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hope Creek Care Center

# 0048694

Report Period Beginning:

12/1/09

Ending:

11/30/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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.  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	18 Welfare Committee	\$	Rock Island County	100.00%	\$ 10,246	\$ 10,246	1
2	V	19 Risk Management		Rock Island County	100.00%	209,859	209,859	2
3	V	19 General Management		Rock Island County	100.00%	8,210	8,210	3
4	V	19 Auditor		Rock Island County	100.00%	21,728	21,728	4
5	V	19 Purchasing		Rock Island County	100.00%	6,071	6,071	5
6	V	19 Information Systems		Rock Island County	100.00%	48,883	48,883	6
7	V	19 Treasurer		Rock Island County	100.00%	342	342	7
8	V	19 County Board		Rock Island County	100.00%	102,651	102,651	8
9	V	22 Worker's Comp		Rock Island County	100.00%	40,177	40,177	9
10	V	22 Unemployment Comp		Rock Island County	100.00%	23,184	23,184	10
11	V	34 County Buildings		Rock Island County	100.00%	849	849	11
12	V							12
13	V							13
14	Total		\$			\$ 472,200	\$ * 472,200	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Hope Creek Care Center

# 0048694

Report Period Beginning:

12/1/09

Ending:

11/30/10

## 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	KAREN CALVILLO	CHAIR, NUR HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	\$ 1,442	18(7)	1
2	STEVE BALLARD	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,213	18(7)	2
3	JOHN BRANDMEYER	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	911	18(7)	3
4	DON JACOBS	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,822	18(7)	4
5	KEN MARANDA	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,214	18(7)	5
6	STEVE MEERSMAN	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,822	18(7)	6
7	FRED SCHULTZ	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,822	18(7)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,246		13

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

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

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Hope Creek Care Center

# 0048694

Report Period Beginning:

12/1/09

Ending: 11/30/10

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	18	Welfare Committee	Cost Allocation Study	100	\$ 10,246	\$	100	\$ 10,246	1
2	19	Risk Management	Cost Allocation Study	100	209,859		100	209,859	2
3	19	General Management	Cost Allocation Study	100	8,210		100	8,210	3
4	19	Auditor	Cost Allocation Study	100	21,728		100	21,728	4
5	19	Purchasing	Cost Allocation Study	100	6,071		100	6,071	5
6	19	Information Systems	Cost Allocation Study	100	48,883		100	48,883	6
7	19	Treasurer	Cost Allocation Study	100	342		100	342	7
8	19	County Board	Cost Allocation Study	100	102,651		100	102,651	8
9	22	Worker's Comp	Actual Cost	100	40,177		100	40,177	9
10	22	Unemployment Comp	Actual Cost	100	23,184		100	23,184	10
11	34	County Buildings	Cost Allocation Study	100	849		100	849	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				\$ 472,200	\$		\$ 472,200	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Hope Creek Care Center

# 0048694

Report Period Beginning:

12/1/09

Ending:

11/30/10

**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										
										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	Bond (2006 Series)		X	Capital Expenditures	Semi-Annual	12/29/06	\$ 9,950,000	\$ 9,140,000	6/1/2027	0.0360	\$ 398,323	1							
2	Bond (2007 Series)		X	Capital Expenditures	Semi-Annual	4/4/07	9,935,000	9,935,000	11/30/2028	0.0400	280,133	2							
3												3							
4												4							
5												5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 19,885,000	\$ 19,075,000			\$ 678,456	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 19,885,000	\$ 19,075,000			\$ 678,456	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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



# 2009 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 \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

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

**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        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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

**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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center

# 0048694

Report Period Beginning:

12/1/09

Ending:

11/30/10

**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?  (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).

N/A

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

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: 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	<u>Non-Facility</u>	<u>280</u>	<u>1917</u>	<u>\$ 18,526</u>	<u>1</u>
2	<u>Facility</u>		<u>2006</u>	<u>1,598,000</u>	<u>2</u>
3	<b>TOTALS</b>	<b>280</b>		<b>\$ 1,616,526</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center

# 0048694

Report Period Beginning:

12/1/09

Ending:

11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	245	2009	2009	\$ 19,711,553	\$	40	\$ 492,764	\$ 492,764	\$ 739,158
5									
6									
7									
8									
Improvement Type**									
9	Front Lawn Landscaping		2009	4,983		10	498	498	747
10	Parking Lots		2009	215,420		30	7,181	7,181	10,771
11									
12	Time Clock		2010	13,500		15	450	450	450
13									
14									
15									
16	Adjustment to agree to financials				28,139			(28,139)	
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center

# 0048694

Report Period Beginning:

12/1/09

Ending:

11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)	\$ 19,945,456	\$ 28,139		\$ 500,893	\$ 472,754	\$ 751,126	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 531,323	\$	\$ 55,346	\$ 55,346	Various	\$ 181,406	71
72	Current Year Purchases	11,410		571	571	10	571	72
73	Fully Depreciated Assets	128,844						73
74								74
75	TOTALS	\$ 671,577	\$	\$ 55,917	\$ 55,917		\$ 181,977	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Ford, Diesel Bus, 1994	1994	\$ 44,742	\$	\$	\$	5	\$ 44,742	76
77	Patient Care	Ford, Taurus, 2002	2002	15,400				5	15,400	77
78	Patient Care	Chevy Pick-Up, 1993	1993	13,527				5	13,527	78
79	Patient Care	Various (See SCH 13A)		109,536		7,212	7,212	5	77,613	79
80	TOTALS			\$ 183,205	\$	\$ 7,212	\$ 7,212		\$ 151,282	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)	\$ 22,416,764	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,139	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 564,022	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 535,883	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,084,385	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	Building - 1948	8,412			87
88	Building - 1950	5,174			88
89	Building - 1954	339,336			89
90	Building - 1967	535,870			90
91	TOTALS	\$ 888,792	\$	\$	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.



Hope Creek Care Center

Provider #: 0012252  
12/1/2009 to 11/30/2010

Schedule 13A

XI. Ownership Costs  
D. Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depr.	Straight Line Depreciation	Life in Years	Accumulated Depreciation
Patient Care	Chevy, Truck, 2002	2001	26,111				26,111
Patient Care	Chevy, Minivan, 2003	2003	33,295				33,295
Patient Care	Chrysler, Town & Country, 2007	2007	21,991		4,398		15,393
Patient Care	Ford Focus, 2010	2010	13,123		1,312		1,312
Patient Care	Ford Fusion, 2010	2010	15,016		1,502		1,502
	Total - Line 79		<u>109,536</u>		<u>7,212</u>		<u>77,613</u>
			<b>To PG 13</b>		<b>To PG 13</b>		<b>To PG 13</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**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			849			6
7	TOTAL				\$ 849			7

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

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

N/A

N/A

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

**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: \$ 13,764 Description: Nursing Equip \$8,259 (Oxygen & Concentrator); Maintenance \$64; Misc \$484; Wound Care \$4,957

(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>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. /2011 \$ \_\_\_\_\_

13. /2012 \$ \_\_\_\_\_

14. /2013 \$ \_\_\_\_\_

\* 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.

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 type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
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.
- SEE ACCOUNTANTS' COMPILATION 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	L10A, C3	hrs	\$	5,798	\$ 467,557	\$ 1,102	5,798	\$ 468,659	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		3,248	200,765	473	3,248	201,238	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		5,890	493,906	1,165	5,890	495,071	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 prescripts				656,219		656,219	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Ambulance</u>	L39, C3				2,948			2,948	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	14,936	\$ 1,165,176	\$ 658,959	14,936	\$ 1,824,135	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center

# 0048694

Report Period Beginning: 12/1/09

Ending: 11/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/10 (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	\$ 371,593	\$ 371,593	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	87,430	87,430	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments	1,440	1,440	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	22,900	22,900	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Due From Other Govt. Unit</u>	571,464	571,464	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,054,827	\$ 1,054,827	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,616,526	13
14	Buildings, at Historical Cost		19,945,456	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		854,782	16
17	Accumulated Depreciation (book methods)		(1,084,385)	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>LT Investments</u> )	2,331,000	2,331,000	22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,331,000	\$ 23,663,379	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,385,827	\$ 24,718,206	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 505,689	\$ 505,689	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	400	400	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	453,174	453,174	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		64,055	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Sch 17A</u>	22,548	22,548	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 981,811	\$ 1,045,866	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	19,075,000	19,075,000	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>	\$ 19,075,000	\$ 19,075,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 20,056,811	\$ 20,120,866	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (16,670,984)	\$ 4,597,340	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,385,827	\$ 24,718,206	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Hope Creek Care Center**

**Provider #:** 0012252  
**12/1/2009** to **11/30/2010**

**Schedule 17A**

XV. Balance Sheet

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Other Current Liabilities - Line 36		
Due From Other Funds	19,514	19,514
Unclaimed Voucher Checks	2,911	2,911
Unclaimed Payroll Checks	123	123
Total - Line 36	<u>22,548</u>	<u>22,548</u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(15,827,550)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(15,827,550)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,253,431)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>(3)</b>	<b>15</b>
<b>16</b>	Other (describe) <b>Bond Principle Payment</b>	<b>410,000</b>	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(843,434)</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>(16,670,984)</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center# 0048694Report Period Beginning: 12/1/09Ending: 11/30/10

**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 13,183,909	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,183,909	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	238,848	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 238,848	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,377	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	28,113	15
16	Rental of Facility Space	225	16
17	Sale of Drugs	2,025	17
18	Sale of Supplies to Non-Patients	6,258	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	7,694	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 47,692	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	23,499	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 23,499	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>See Sch 19A</u>	2,249,482	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,249,482	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 15,743,430	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	2,867,389	31
32	Health Care	7,617,082	32
33	General Administration	3,125,406	33
<b>B. Capital Expense</b>			
34	Ownership	656,304	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	2,596,542	35
36	Provider Participation Fee	134,138	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 16,996,861	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,253,431)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,253,431)	43

\* 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.  
Governmental Entity

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

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



**Hope Creek Care Center**

**Provider #:** 0012252  
**12/1/2009** to **11/30/2010**

**Schedule 19A**

XVII. Income Statement

Line 28 Other Income(specify):

<u>Description</u>	<u>Amount</u>
Transfer from Nursing Home Tax Levy	2,252,519
Transportation Rev	594
Miscellaneous other revenue	<u>(3,631)</u>
Total - Line 28	<u><u>2,249,482</u></u>

**SEE ACCOUNTANTS' COMPILATION REPORT**

Facility Name & ID Number Hope Creek Care Center

# 0048694

Report Period Beginning:

12/1/09

Ending:

11/30/10

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	1,999	2,080	\$ 55,105	\$ 26.49	1
2	Assistant Director of Nursing	2,186	2,126	53,039	24.95	2
3	Registered Nurses	30,987	28,344	690,269	24.35	3
4	Licensed Practical Nurses	79,335	77,756	1,431,639	18.41	4
5	CNAs & Orderlies	254,389	253,207	3,192,489	12.61	5
6	CNA Trainees			-		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,269	6,150	120,027	19.52	8
9	Activity Director	1,871	2,185	39,532	18.09	9
10	Activity Assistants	28,253	29,100	260,909	8.97	10
11	Social Service Workers	6,443	13,535	120,361	8.89	11
12	Dietician					12
13	Food Service Supervisor	4,279	4,344	73,513	16.92	13
14	Head Cook	16,842	8,524	214,809	25.20	14
15	Cook Helpers/Assistants	42,962	35,395	430,980	12.18	15
16	Dishwashers					16
17	Maintenance Workers	11,577	13,319	271,228	20.36	17
18	Housekeepers	35,533	21,924	405,262	18.48	18
19	Laundry	25,228	17,428	263,153	15.10	19
20	Administrator	2,088	2,112	72,620	34.38	20
21	Assistant Administrator	943	2,173	30,056	13.83	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,336	9,657	173,954	18.01	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	2,246	2,176	29,639	13.62	31
32	Other Health C: Memory Care Co	4,279	4,100	82,053	20.01	32
33	Other(specify) Stock Room	300	213	5,062	23.77	33
34	TOTAL (lines 1 - 33)	571,345	535,848	\$ 8,015,699 *	\$ 14.96	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	490	\$ 22,593	1(3)	35
36	Medical Director	Monthly	27,987	9(3)	36
37	Medical Records Consultant	Monthly	55,527	10(3)	37
38	Nurse Consultant	Monthly	250,253	10(3)	38
39	Pharmacist Consultant	Monthly	15,642	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	10	760	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	500	\$ 372,762		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center

Report Period Beginning: 12/1/09

**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		
Trudy Whittington	Administrator	0	\$ 71,069	Workers' Compensation Insurance	\$ 40,177	IDPH License Fee	\$		
Sheryl Thomas	Asst. Administrator	0	31,607	Unemployment Compensation Insurance	23,184	Advertising: Employee Recruitment			
				FICA Taxes	594,820	Health Care Worker Background Check			
				Employee Health Insurance	1,358,682	(Indicate # of checks performed 470 )	5,638		
				Employee Meals		Patient Background Checks	3,760		
				Illinois Municipal Retirement Fund (IMRF)*	746,219	Publishing	4,625		
				Employee Fitness	14,339				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 102,676						
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	
N/A			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	9,893	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$ 2,777,421	TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
See Sch 21A			\$ 397,743	N/A		\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense	9,893	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 397,743	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	

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

\*\*See instructions.

**Hope Creek Care Center**

**Provider #:** 0012252  
**12/1/2009 to** 11/30/2010

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Brought forward from page 21

Vendor

Type

-

Total agreeing to Schedule V, Line 19, Col 3

-

County Allocated Expenses (See Page 8)

Risk Management	209,859
General Management	8,210
Auditor	21,728
Purchasing	6,071
Information Systems	48,883
Treasurer	342
County Board	102,650

Total (agree to Schedule V, line 19, column 8)

397,743

**SEE ACCOUNTANTS' COMPILATION REPORT**

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Hope Creek Care Center

# 0048694

Report Period Beginning: 12/1/09

Ending: 11/30/10

**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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 67,734 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. \$ 134,138  
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. \$ 0  
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: McGladrey & Pullen, LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**