		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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 12/01/17 to 11/30/18 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: 12/01/17 Ending: 11/30/18

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	17,335	101	3,960	21,396	8
9	SNF/PED					9
10	ICF	19,577	13,099	4,416	37,092	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,912	13,200	8,376	58,488	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.40%

D. How many bed reserve days during this year were paid by the Department?
N/A (Do not include bed reserve 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 2,462

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: 11/30/2018 Fiscal Year: 11/30/2018

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	694,963	63,332	22,595	780,890		780,890	-	780,890			1
2	Food Purchase		395,517		395,517		395,517	(156)	395,361			2
3	Housekeeping	347,914	45,704	4,035	397,653		397,653	-	397,653			3
4	Laundry	277,594	15,561	-	293,155	0	293,155	-	293,155			4
5	Heat and Other Utilities			287,897	287,897		287,897	-	287,897			5
6	Maintenance	202,797	52,667	90,558	346,022		346,022	-	346,022			6
7	Other (specify):*	-	-	-	0		0	-	0			7
8	**TOTAL General Services**	1,523,268	572,781	405,085	2,501,134	0	2,501,134	(156)	2,500,978			8
	B. Health Care and Programs											
9	Medical Director	-	-	-	0	20,000	20,000	-	20,000			9
10	Nursing and Medical Records	5,303,240	195,514	992,932	6,491,686	(20,000)	6,471,686	(9,426)	6,462,260			10
10a	Therapy	193,486	-	-	193,486		193,486	-	193,486			10a
11	Activities	344,037	2,101	774	346,912		346,912	-	346,912			11
12	Social Services	177,375	21	-	177,396		177,396	(41,265)	136,131			12
13	CNA Training	-	-	-	0		0	-	0			13
14	Program Transportation	-	-	-	0		0	-	0			14
15	Other (specify):*	-	-	-	0		0	-	0			15
16	**TOTAL Health Care and Programs**	6,018,138	197,636	993,706	7,209,480	0	7,209,480	(50,691)	7,158,789			16
	C. General Administration											
17	Administrative	-	-	-	0	105,220	105,220	-	105,220			17
18	Directors Fees			-	0		0	12,326	12,326			18
19	Professional Services			-	0	70,700	70,700	356,610	427,310			19
20	Dues, Fees, Subscriptions & Promotions			7,872	7,872		7,872	-	7,872			20
21	Clerical & General Office Expenses	454,652	20,920	223,562	699,134	(175,920)	523,214	(195)	523,019			21
22	Employee Benefits & Payroll Taxes			1,778,204	1,778,204		1,778,204	1,835,431	3,613,635			22
23	Inservice Training & Education			-	0		0	-	0			23
24	Travel and Seminar			6,972	6,972		6,972	-	6,972			24
25	Other Admin. Staff Transportation		-	5,645	5,645		5,645	-	5,645			25
26	Insurance-Prop.Liab.Malpractice			48,656	48,656		48,656	-	48,656			26
27	Other (specify):*	-	-	-	0		0	-	0			27
28	**TOTAL General Administration**	454,652	20,920	2,070,911	2,546,483	0	2,546,483	2,204,172	4,750,655			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,996,058	791,337	3,469,702	12,257,097	0	12,257,097	2,153,325	14,410,422			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: 12/01/17 Ending: 11/30/18

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			-	0		0	559,468	559,468			30
31	Amortization of Pre-Op. & Org.			-	0		0	-	0			31
32	Interest			447,518	447,518		447,518	(3,017)	444,501			32
33	Real Estate Taxes			-	0		0	-	0			33
34	Rent-Facility & Grounds			-	0		0	192	192			34
35	Rent-Equipment & Vehicles			18,519	18,519		18,519	-	18,519			35
36	Other (specify):*			-	0		0	-	0			36
37	TOTAL Ownership			466,037	466,037	0	466,037	556,643	1,022,680			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-	0		0	-	0			38
39	Ancillary Service Centers	-	270,216	550,678	820,894		820,894	-	820,894			39
40	Barber and Beauty Shops	-	-	-	0		0	-	0			40
41	Coffee and Gift Shops	-	-	-	0		0	-	0			41
42	Provider Participation Fee			-	0		0	474,215	474,215			42
43	Other (specify):* Non-Allowable Cos	33,593	7,964	716,557	758,114		758,114	(758,114)	0			43
44	TOTAL Special Cost Centers	33,593	278,180	1,267,235	1,579,008	0	1,579,008	(283,899)	1,295,109			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,029,651	1,069,517	5,202,974	14,302,142	0	14,302,142	2,426,069	16,728,211			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: 12/01/17 Ending: 11/30/18

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	(156)	2		4
5	Telephone, TV & Radio in Resident Rooms	(29,080)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(9,426)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	559,468	30		9
10	Interest and Other Investment Income	(3,017)	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	(1)	43		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 PG5A	(296,278)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 221,510		$ 0	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)	2,204,559		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,204,559		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 2,426,069		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Hope Creek Care Center

ID# 0048694

Report Period Beginning: 12/01/17

Ending: 11/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (10,927)	43	1
2	Principal	(665,000)	43	2
3	Operating Supplies	(1,593)	43	3
4	Professional Services	(6,616)	43	4
5	Communications	(4,923)	43	5
6	Dues & Memberships	(10)	43	6
7	Reclass Provider Bed Tax	474,215	42	7
8	Misc Income	(195)	21	8
9	Publishing	(5,513)	43	9
10	Food Purchases	(858)	43	10
11	Marketing Salary	(33,593)	43	11
12	Admissions Coordinator Salary	(41,265)	12	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(296,278)		49

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

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	1	$ 12,326	$ 12,326	1
2	V	19	Risk Management		Rock Island County	1	218,788	218,788	2
3	V	19	General Management		Rock Island County	1	14,259	14,259	3
4	V	19	Auditor		Rock Island County	1	23,158	23,158	4
5	V	19	Information Systems		Rock Island County	1	40,119	40,119	5
6	V	19	Treasurer		Rock Island County	1	314	314	6
7	V	19	County Board		Rock Island County	1	59,972	59,972	7
8	V	22	Worker's Comp		Rock Island County	1	136,695	136,695	8
9	V	22	FICA		Rock Island County	1	593,119	593,119	9
10	V	22	IMRF		Rock Island County	1	1,105,617	1,105,617	10
11	V	34	County Buildings		Rock Island County	1	192	192	11
12	V								12
13	V								13
14	Total			$			$ 2,204,559	$ * 2,204,559	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: 12/01/17 Ending: 11/30/18

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

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	Jessey Hullon	CHAIR, NUR HM C(	DIRECTOR	0					$ 3,582	18(7)	1
2	Michael Kelly	NURS HM COMM	DIRECTOR	0					1,457	18(7)	2
3	Ginny Shelton	NURS HM COMM	DIRECTOR	0					1,457	18(7)	3
4	Rod Simmer	NURS HM COMM	DIRECTOR	0					1,457	18(7)	4
5	Carol Near	NURS HM COMM	DIRECTOR	0					1,457	18(7)	5
6	Tim Erno	NURS HM COMM	DIRECTOR	0					1,457	18(7)	6
7	Bryon Tyson	NURS HM COMM	DIRECTOR	0					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: 12/01/17 Ending: 11/30/18

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	1		$ 12,326	$ 12,326	1	$ 12,326	1
2	19	Risk Management	Cost Allocation Study	1		218,788		1	218,788	2
3	19	General Management	Cost Allocation Study	1		14,259		1	14,259	3
4	19	Auditor	Cost Allocation Study	1		23,158		1	23,158	4
5	19	Information Systems	Cost Allocation Study	1		40,119		1	40,119	5
6	19	Treasurer	Cost Allocation Study	1		314		1	314	6
7	19	County Board	Cost Allocation Study	1		59,972		1	59,972	7
8	22	Worker's Comp	Cost Allocation Study	1		136,695		1	136,695	8
9	22	FICA	Cost Allocation Study	1		593,119		1	593,119	9
10	22	IMRF	Cost Allocation Study	1		1,105,617		1	1,105,617	10
11	34	County Buildings	Cost Allocation Study	1		192		1	192	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					$ 2,204,559	$ 12,326		$ 2,204,559	25

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bond (2006 Series)		X	Capital Expenditures	Semi-Annual	12/29/06	$ 9,950,000	$	6/1/2027	0.0360	$	1
2	Bond (2007 Series)		X	Capital Expenditures	Semi-Annual	4/4/07	9,935,000		11/30/2028	0.0400		2
3	Bond (2013 Series)		X	Capital Expenditures	Semi-Annual	5/9/2013	3,700,000	3,380,000	12/1/2024	0.0200	88,593	3
4	Bond (2016 Series)		X	Capital Expenditures	Semi-Annual	9/27/2016	9,105,000	8,825,000	12/1/2027	0.0200	358,925	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 32,690,000	$ 12,205,000			$ 447,518	9
	B. Non-Facility Related*											
10												10
11								Interest Income			(3,017)	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ (3,017)	14
15	TOTALS (line 9+line14)						$ 32,690,000	$ 12,205,000			$ 444,501	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: 12/01/17 Ending: 11/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 0	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.)	2017	$	2
3. Under or (over) accrual (line 2 minus line 1).		$ 0	3
4. Real Estate Tax accrual used for 2018 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.)**	Alloc Fr. Mgmt Co.	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

County Facility-Exempt from real estate taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 Patty Luecke

TELEPHONE (309) 796-6716 FAX #: (309) 796-6601

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(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	$ 0.00	$ 0.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 12/01/17 Ending: 11/30/18

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	0	2006	1,598,000	2
3	TOTALS	280		$ 1,616,526	3

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

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	$ 4,681,270	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Front Lawn Landscaping		2009	2009	4,983	-	10	498	498	4,731	9
10	Parking Lots		2009	2009	215,420	-	30	7,181	7,181	68,219	10
11						-		-			11
12	Time Clock		2010	2010	13,500	-	15	900	900	7,650	12
13						-		-			13
14	Trane Furnace & AC in HCC Annex Bldg		2014	2014	6,724	-	10	672	672	3,026	14
15						-		-			15
16	Picnic Pavilion		2015	2015	157,830	-	20	7,892	7,892	27,620	16
17	2 Thermostats - Rooftop Unit 12 on Building 5		2015	2015	2,645	-	10	265	265	926	17
18						-		-			18
19	Carpet - Dining Room		2016	2016	17,557	-	5	1,756	1,756	5,268	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: 12/01/17 Ending: 11/30/18

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)		$ 20,130,212	$ 0		$ 511,927	$ 511,927	$ 4,798,709	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: 12/01/17 Ending: 11/30/18

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	$ 716,451	$	$ 40,359	$ 40,359	7	$ 667,301	71
72	Current Year Purchases				-			72
73	Fully Depreciated Assets	26,664			-		26,664	73
74					-			74
75	TOTALS	$ 743,115	$ 0	$ 40,359	$ 40,359		$ 693,965	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)		106,210	-	7,182	7,182	5	78,681	79
80	TOTALS			$ 190,590	$ 0	$ 7,182	$ 7,182		$ 163,061	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)	$ 22,680,443	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 0	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 559,468	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 559,468	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,655,735	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: **11/30/18**

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, Minivan	2003	33,295			-	5	33,295
Patient Care	Chrysler Town	2007	21,991			-	5	21,991
Patient Care	Ford Fusion 2010	2010	15,016			-	5	15,016
Patient Care	Grand Caravan	2017	35,908		7,182	-	5	8,379
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			**106,210**	**-**	**7,182**	**-**		**78,681**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

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			192			6
7	TOTAL				$ 192 **			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 ☒ N/A 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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 18,519 Description: See Schedule 14A
(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: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/18**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Oxygen, matress & Concentrator	12,326
Maint. Equipment	88
Wound Care	4,487
Booth Rental	318
Extractor Rental	1,300
Total - Line 16	**18,519**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$ 0
2	Books and Supplies					0
3	Classroom Wages	(a)				0
4	Clinical Wages	(b)				0
5	In-House Trainer Wages	(c)				0
6	Transportation					0
7	Contractual Payments					0
8	CNA Competency Tests					0
9	TOTALS		$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2	(e)	$ 0			

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: 12/01/17 Ending: 11/30/18

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

		1	2	3	4	5	6	7	8	
	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	L39, C3	hrs	$	4,492	$ 225,128	$	4,492	$ 225,128	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,657	85,547		1,657	85,547	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		5,158	240,053		5,158	240,053	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				255,058		255,058	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					15,158		15,158	12
13	Other (specify): Ambulance					(50)			(50)	13
14	TOTAL			$	11,307	$ 550,678	$ 270,216	11,307	$ 820,894	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: 12/01/17 Ending: 11/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/18 (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	$ 53,192	$ 53,192	1
2	Cash-Patient Deposits	0	0	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (1,239,478))	1,631,603	1,631,603	3
4	Supply Inventory (priced at)	0	0	4
5	Short-Term Investments	204,000	204,000	5
6	Prepaid Insurance	0	0	6
7	Other Prepaid Expenses	172	172	7
8	Accounts Receivable (owners or related parties)	851,234	851,234	8
9	Other(specify): See Sch 17A	31,100	31,100	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,771,301	$ 2,771,301	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0	0	11
12	Long-Term Investments	0	0	12
13	Land	0	1,616,526	13
14	Buildings, at Historical Cost	0	19,711,553	14
15	Leasehold Improvements, at Historical Cost	0	418,659	15
16	Equipment, at Historical Cost	0	933,705	16
17	Accumulated Depreciation (book methods)	0	(5,655,735)	17
18	Deferred Charges	0	0	18
19	Organization & Pre-Operating Costs	0	0	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0	0	20
21	Restricted Funds	0	0	21
22	Other Long-Term Assets (spc	0	0	22
23	Other(specify):	0	0	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 0	$ 17,024,708	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,771,301	$ 19,796,009	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,006,457	$ 2,006,457	26
27	Officer's Accounts Payable	0	0	27
28	Accounts Payable-Patient Deposits	0	0	28
29	Short-Term Notes Payable	0	0	29
30	Accrued Salaries Payable	311,791	311,791	30
31	Accrued Taxes Payable (excluding real estate taxes)	0	0	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	0	32
33	Accrued Interest Payable	0	0	33
34	Deferred Compensation	0	0	34
35	Federal and State Income Taxes	0	0	35
	Other Current Liabilities(specify):			
36	See Sch 17A	4,349,978	4,349,978	36
37	See Sch 17A	4,466	4,466	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,672,692	$ 6,672,692	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	0	0	39
40	Mortgage Payable	0	0	40
41	Bonds Payable	0	12,205,000	41
42	Deferred Compensation	0	0	42
	Other Long-Term Liabilities(specify):			
43		0	0	43
44		0	0	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 12,205,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,672,692	$ 18,877,692	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,901,391)	$ 918,317	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,771,301	$ 19,796,009	48

*(See instructions.)

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/18**

Schedule 17A

XV. Balance Sheet
Line 9 Current Assets Other (specify):

Description	Operating	After Consolidation
A/R NSF Checks/stop Payment	30,974	30,974
Int. Rec. on Investments	126	126
Total - Line 9	**31,100**	**31,100**

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

Description	Operating	After Consolidation
Est. Uncoll. Due From	1,337,252	1,337,252
Due Other Funds	1,287,000	1,287,000
Due other funds-transfers	51	51
Rev/Tax anticipation loan payable	1,382,000	1,382,000
Deferred Revenue	343,675	343,675
Total - Line 36	**4,349,978**	**4,349,978**

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

Description	Operating	After Consolidation
Deposits	400	400
Unclaimed Voucher Checks	2,914	2,914
Unclaimed Voucher Checks	1,152	1,152
Total - Line 37	**4,466**	**4,466**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,286,475)	1	
2	Restatements (describe):		2	
3	**Prior period adjustment**	(131,758)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,418,233)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,483,158)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,483,158)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,901,391)	24	*

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

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	$ 10,444,525	1
2	Discounts and Allowances for all Levels	(0)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,444,525	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	142,723	6
7	Oxygen	0	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 142,723	8
	C. Other Operating Revenue		
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	CNA Training Reimbursements	0	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	156	14
15	Telephone, Television and Radio	10,236	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	0	17
18	Sale of Supplies to Non-Patients	9,426	18
19	Laboratory	0	19
20	Radiology and X-Ray	0	20
21	Other Medical Services	0	21
22	Laundry	3,578	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,396	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	3,017	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,017	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		0	28
28a	See Sch 19A	2,205,323	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,205,323	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,818,984	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,501,134	31
32	Health Care	7,209,480	32
33	General Administration	2,546,483	33
	B. Capital Expense		
34	Ownership	466,037	34
	C. Ancillary Expense		
35	Special Cost Centers	1,579,008	35
36	Provider Participation Fee	0	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,302,142	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,483,158)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,483,158)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,244,514	44
45	Private Pay - Net Inpatient Revenue	125,355	45
46	Medicare - Net Inpatient Revenue	1,734,864	46
47	Other-(specify) Patient Fees	2,592,885	47
48	Other-(specify) Vetrans	746,907	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,444,525	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.**

^ Entity is a cash basis taxpayer

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/18**

Schedule 19A

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

Description	Amount
IGT-Inter governmental transfer funds	640,161
Transportation charge	1,929
CPR Training fees	40
Refunds/rebates for prior years	37,235
Miscellaneous-other revenue	195
Transfre from nurse home taxlevy	2,643,123
Sales of capital assets	9,018
Sales of junk or salvage value	303
Bond Escrow Refund	
Transfer to General Fund	(694,134)
Transfer to Other Agencies	(358,539)
Transfer of Medicare cost overpayment prior year	(74,008)
Total - Line 28	**2,205,323**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

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	1,781	2,155	$ 78,146	$ 36.26	1
2	Assistant Director of Nursing	1,455	1,576	58,851	37.34	2
3	Registered Nurses	15,785	18,315	499,064	27.25	3
4	Licensed Practical Nurses	50,515	61,580	1,331,791	21.63	4
5	CNAs & Orderlies	184,104	218,349	3,203,890	14.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,564	10,494	193,486	18.44	8
9	Activity Director	1,984	2,080	53,269	25.61	9
10	Activity Assistants	19,276	20,327	290,768	14.30	10
11	Social Service Workers	5,335	6,601	136,110	20.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	46,285	51,399	694,963	13.52	15
16	Dishwashers					16
17	Maintenance Workers	8,692	9,932	202,797	20.42	17
18	Housekeepers	16,133	25,008	347,914	13.91	18
19	Laundry	16,035	18,431	277,594	15.06	19
20	Administrator	1,792	2,080	105,220	50.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,814	15,061	349,432	23.20	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 C: See Sch 20A	5,820	6,442	131,498	20.41	32
33	Other(specify) See Sch 20A	2,877	3,467	74,858	21.59	33
34	TOTAL (lines 1 - 33)	400,247	473,297	$ 8,029,651 *	$ 16.97	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	$ 22,595	1(3)	35
36	Medical Director	Monthly	20,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,451	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	774	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 44,820		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7,115	$ 325,748	10(3)	50
51	Licensed Practical Nurses	11,844	458,931	10(3)	51
52	Certified Nurse Assistants/Aides	7,865	186,802	10(3)	52
53	TOTAL (lines 50 - 52)	26,824	$ 971,481		53

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/18**

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
MDS Reimbursement Manager	1,971	2,084	43,071	$ 20.67
Central Supply Clerk	1,946	2,267	42,922	$ 18.93
Memory Care Coordinator	1,903	2,091	45,505	$ 21.76
Total - Line 32 Other Health Care (specify):	**5,820**	**6,442**	**131,498**	

XVIII. Staffing and Salary Costs
Line 33 Other (specify):

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
Admissions Coordinator	1,748	2,107	41,265	$ 19.58
Marketing Director	1,129	1,360	33,593	$ 24.70
Total - Line 33 Other (specify):	**2,877**	**3,467**	**74,858**	

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
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	$
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	$ 136,695
Unemployment Compensation Insurance	
FICA Taxes	593,119
Employee Health Insurance	1,441,829
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	1,105,617
Uniform Clothing	45,000
Other Employee Benefits	291,375
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,613,635

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 29)	991
Patient Background Checks 338	3,802
Publishing	1,422
Miscellaneous Dues & Subscriptions	1,657
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,872

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,972
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,972

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/18**

Schedule 21A

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership	Amount
Cassandra Baker	Administrator	0%	105,220

Total (agree to Schedule V, line 17, Column 7)

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/18**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
	Total (agree to Schedule V, line 19, column 3)	-
Allocated from County	Auditor	23,158
Allocated from County	County Board	59,972
Allocated from County	General Management	14,259
Allocated from County	Information Systems	40,119
Allocated from County	Risk Management	218,788
Allocated from County	Tresurer	314
Gabelmann & Associates	Accounting	7,500
RSM US LLP	Accounting	10,700
Honkamp Krueger & Co.	Accounting	52,500
	Total (agree to Schedule V, line 19, column 8)	427,310

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/17 Ending: 11/30/18

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? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **55,309** 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. $ **474,215**
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? **Yes** Indicate the amount. $ **156**

(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: **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.