FOR BHF USE

LL1

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.

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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) 796-6601

HFS ID Number: 36-600-6649-001

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: Michael W. Martin **Telephone Number:** (217) 258-8888
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/08 to 11/30/09 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) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey & Pullen, 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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	9,429	2,631	7,028	19,088	8
9	SNF/PED					9
10	ICF	40,559	16,294	38	56,891	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,988	18,925	7,066	75,979	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.96%

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 [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 20 and days of care provided 6,694

Medicare Intermediary Wisconsin Physicians Services

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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	629,381	55,607	24,438	709,426		709,426		709,426			1
2	Food Purchase		517,297		517,297		517,297		517,297			2
3	Housekeeping	326,969	59,905	5,670	392,544		392,544		392,544			3
4	Laundry	226,121	38,301	243	264,665		264,665		264,665			4
5	Heat and Other Utilities			291,179	291,179		291,179		291,179			5
6	Maintenance	279,084	93,610	40,191	412,885		412,885		412,885			6
7	Other (specify):*											7
8	TOTAL General Services	1,461,555	764,720	361,721	2,587,996		2,587,996		2,587,996			8
	B. Health Care and Programs											
9	Medical Director			24,199	24,199		24,199		24,199			9
10	Nursing and Medical Records	4,466,010	296,648	71,230	4,833,888		4,833,888		4,833,888			10
10a	Therapy	103,762	3,049	715,340	822,151		822,151		822,151			10a
11	Activities	190,711		195	190,906		190,906		190,906			11
12	Social Services	92,420	6,995		99,415		99,415		99,415			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,852,903	306,692	810,964	5,970,559		5,970,559		5,970,559			16
	C. General Administration											
17	Administrative	133,224			133,224		133,224		133,224			17
18	Directors Fees							10,246	10,246			18
19	Professional Services							408,792	408,792			19
20	Dues, Fees, Subscriptions & Promotions			7,536	7,536		7,536		7,536			20
21	Clerical & General Office Expenses	129,133	16,811	96,946	242,890		242,890		242,890			21
22	Employee Benefits & Payroll Taxes			2,330,999	2,330,999		2,330,999	86,556	2,417,555			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,470	10,470		10,470	(289)	10,181			24
25	Other Admin. Staff Transportation			6,324	6,324		6,324		6,324			25
26	Insurance-Prop.Liab.Malpractice			20,161	20,161		20,161		20,161			26
27	Other (specify):*											27
28	TOTAL General Administration	262,357	16,811	2,472,436	2,751,604		2,751,604	505,305	3,256,909			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,576,815	1,088,223	3,645,121	11,310,159		11,310,159	505,305	11,815,464			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 & ID Number Hope Creek Care Center #0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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							289,237	289,237			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			206,361	206,361		206,361		206,361			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							849	849			34
35	Rent-Equipment & Vehicles			75,441	75,441		75,441		75,441			35
36	Other (specify):* **Donated Goods**							4,850	4,850			36
37	**TOTAL Ownership**			281,802	281,802		281,802	294,936	576,738			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		263,575	2,271	265,846		265,846		265,846			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,335,376	1,335,376		1,335,376		1,335,376			42
43	Other (specify):* **Non-allowable cost**		37,316	1,889,971	1,927,287		1,927,287	(1,927,287)				43
44	**TOTAL Special Cost Centers**		300,891	3,227,618	3,528,509		3,528,509	(1,927,287)	1,601,222			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,576,815	1,389,114	7,154,541	15,120,470		15,120,470	(1,127,046)	13,993,424			45

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

****** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	289,237	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(1,927,575)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,638,338)		$	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*	4,850	36	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	506,442		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 511,292		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,127,046)		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

SEE ACCOUNTANTS' COMPILATION REPORT

Hope Creek Care Center

ID# 0048694

Report Period Beginning: 12/1/08

Ending: 11/30/09

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab - Part A	$ (16,928)	43	1
2	X-Ray - Part A	(2,618)	43	2
3	Offset Transfer to Other Funds	(1,825,094)	43	3
4	Marketing Expenses	(45,330)	43	4
5	Marketing Supplies	(37,316)	43	5
6	Unsupported Travel & Seminar Expense	(289)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,927,575)		49

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Welfare Committee	$	Rock Island County	100.00%	$ 10,246	$ 10,246	1
2	V	19	Risk Management		Rock Island County	100.00%	209,950	209,950	2
3	V	19	General Management		Rock Island County	100.00%	11,253	11,253	3
4	V	19	Auditor		Rock Island County	100.00%	23,089	23,089	4
5	V	19	Purchasing		Rock Island County	100.00%	5,495	5,495	5
6	V	19	Information Systems		Rock Island County	100.00%	50,398	50,398	6
7	V	19	Treasurer		Rock Island County	100.00%	327	327	7
8	V	19	County Board		Rock Island County	100.00%	108,279	108,279	8
9	V	22	Worker's Comp		Rock Island County	100.00%	70,457	70,457	9
10	V	22	Unemployment Comp		Rock Island County	100.00%	16,099	16,099	10
11	V	34	County Buildings		Rock Island County	100.00%	849	849	11
12	V								12
13	V								13
14	Total			$			$ 506,442	$ * 506,442	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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	KAREN CALVILLO	CHAIR, NUR HM C(	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	1,214	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	1,821	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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Welfare Committee	Cost Allocation Study	100		$ 10,246	$	100	$ 10,246	1
2	19	Risk Management	Cost Allocation Study	100		209,950		100	209,950	2
3	19	General Management	Cost Allocation Study	100		11,253		100	11,253	3
4	19	Auditor	Cost Allocation Study	100		23,089		100	23,089	4
5	19	Purchasing	Cost Allocation Study	100		5,495		100	5,495	5
6	19	Information Systems	Cost Allocation Study	100		50,398		100	50,398	6
7	19	Treasurer	Cost Allocation Study	100		327		100	327	7
8	19	County Board	Cost Allocation Study	100		108,279		100	108,279	8
9	22	Worker's Comp	Actual Cost	100		70,457		100	70,457	9
10	22	Unemployment Comp	Actual Cost	100		16,099		100	16,099	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					$ 506,442	$		$ 506,442	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bond (2006 Series)		X	Capital Expenditures	Semi-Annual	12/29/06	$ 9,950,000	$ 9,550,000	6/1/2027	0.0360	$ 206,361	1
2	Bond (2007 Series)		X	Capital Expenditures	Semi-Annual	4/4/07	9,935,000	9,935,000	11/30/2028	0.0400		2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 19,885,000	$ 19,485,000			$ 206,361	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 19,885,000	$ 19,485,000			$ 206,361	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.)**

Facility Name & ID Number Hope Creek Care Center **#** 0048694 **Report Period Beginning:** 12/1/08 **Ending:** 11/30/09

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		N/A	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.)	2008	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2009 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.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2004	8
	2005	9
	2006	10
	2007	11
	2008	12

County Facility

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 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 2008 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 2008.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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: 12/1/08 Ending: 11/30/09

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 120,731 B. General Construction Type: Exterior Brick Frame Block & Brick Number of Stories 2

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	Acres 280	1917	$ 18,526	1
2	Facility		2006	1,598,000	2
3	TOTALS	280		$ 1,616,526	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	$ 246,394	$ 246,394	$ 246,394	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Front Lawn Landscaping			2009	4,983		10	249	249	249	9
10	Parking Lots			2009	215,420		30	3,590	3,590	3,590	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	Cash Basis Expense for current year are zero										33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)		$ 19,931,956	$		$ 250,233	$ 250,233	$ 250,233	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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	$ 138,672	$	$ 13,867	$ 13,867	Various	$ 13,867	71
72	Current Year Purchases	414,787		20,739	20,739		20,739	72
73	Fully Depreciated Assets	91,454				Various	91,454	73
74								74
75	TOTALS	$ 644,913	$	$ 34,606	$ 34,606		$ 126,060	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)		81,397		4,398	4,398	5	70,401	79
80	TOTALS			$ 155,066	$	$ 4,398	$ 4,398		$ 144,070	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)	$ 22,348,461	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 289,237	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 289,237	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 520,363	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	Land - 1917	$ 18,526	$	$	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	$ 907,318	$	$	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
12/1/2008 to 11/30/2009 **Schedule 13A**

XI. Ownership Costs
D. Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depr.	Straight Line Depreciation	Adjustments	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			10,995
	Total - Line 79		81,397		4,398			70,401
			To PG 13		**To PG 13**			**To PG 13**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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 [X] 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. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease .

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2010	$
13.	/2011	$
14.	/2012	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 75,441 Description: Nursing Equip $72,641 (Oxygen & Concentrator); Maintenance $2,620; Misc $180
    (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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	3,988	$	323,134	$ 1,378	3,988	$ 324,512	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,420		90,643	386	1,420	91,029	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(3)	hrs		3,804		301,563	1,285	3,804	302,848	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39(2)	# of prescrpts					263,575		263,575	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): Ambulance	39(3)					2,271			2,271	12
13	Other (specify):										13
14	TOTAL			$	9,212	$	717,611	$ 266,624	9,212	$ 984,235	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

STATE OF ILLINOIS

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/09 (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	$ 4,006	$ 4,006	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	586,461	586,461	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	3,108	3,108	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,171	15,171	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Other Govt. Unit	611,749	611,749	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,220,495	$ 1,220,495	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,616,526	13
14	Buildings, at Historical Cost		19,931,956	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		799,979	16
17	Accumulated Depreciation (book methods)		(520,363)	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 LT Investments	3,306,000	3,306,000	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,306,000	$ 25,134,098	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,526,495	$ 26,354,593	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 519,525	$ 519,525	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	345,501	345,501	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See SCH 17A	3,619	3,619	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 869,045	$ 869,045	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	19,485,000	19,485,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 19,485,000	$ 19,485,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 20,354,045	$ 20,354,045	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (15,827,550)	$ 6,000,548	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,526,495	$ 26,354,593	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Hope Creek Care Center
Provider #: 0012252
12/1/2008 to 11/30/2009 **Schedule 17A**

XV. Balance Sheet

Description	Operating	After Consolidation
Other Current Liabilities - Line 36		
Due From Other Funds	585	585.00
Unclaimed Voucher Checks	2,911	2911.00
Unclaimed Payroll Checks	123	123.00
Total - Line 36	3,619	3,619

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,241,609	1
2	Restatements (describe):		2
3	**Reporting Bonds Payable**	(19,485,000)	3
4	**Prior Period Adjustment**	(1,547,214)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (16,790,605)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	963,055	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)**	$ 963,055	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (15,827,550)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,391,802	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 13,391,802	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	202,453	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 202,453	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,408	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	13,835	15
16	Rental of Facility Space	225	16
17	Sale of Drugs	8,712	17
18	Sale of Supplies to Non-Patients	10,395	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	18,999	21
22	Laundry	11,885	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 66,459	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	98,995	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 98,995	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See SCH 19A	2,323,816	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,323,816	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,083,525	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,587,996	31
32	Health Care	5,970,559	32
33	General Administration	2,751,604	33
	B. Capital Expense		
34	Ownership	281,802	34
	C. Ancillary Expense		
35	Special Cost Centers	2,193,133	35
36	Provider Participation Fee	1,335,376	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,120,470	40
41	**Income before Income Taxes (line 30 minus line 40)****	963,055	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 963,055	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
12/1/2008 to 11/30/2009 **Schedule 19A**

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

Description	Amount
Transfer from Nursing Home Tax Levy	2,323,000
Sales of Junk or Salvage	200
Transportation Rev	616
Total - Line 28	2,323,816

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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	970	1,075	$ 28,020	$ 26.07	1
2	Assistant Director of Nursing	1,797	2,126	55,434	26.07	2
3	Registered Nurses	20,436	22,229	540,740	24.33	3
4	Licensed Practical Nurses	64,949	72,572	1,336,052	18.41	4
5	CNAs & Orderlies	178,856	195,009	2,462,553	12.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,018	6,115	103,762	16.97	8
9	Activity Director	1,744	2,185	50,420	23.08	9
10	Activity Assistants	9,664	10,947	140,291	12.82	10
11	Social Service Workers	4,530	5,360	92,420	17.24	11
12	Dietician					12
13	Food Service Supervisor	3,387	4,344	83,737	19.28	13
14	Head Cook	7,516	8,524	129,204	15.16	14
15	Cook Helpers/Assistants	31,390	35,395	416,440	11.77	15
16	Dishwashers					16
17	Maintenance Workers	11,224	13,319	279,084	20.95	17
18	Housekeepers	18,754	21,924	326,969	14.91	18
19	Laundry	14,944	17,428	226,121	12.97	19
20	Administrator	1,884	2,112	71,069	33.65	20
21	Assistant Administrator	1,765	2,173	62,155	28.60	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,747	9,657	129,133	13.37	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	1,949	2,176	27,268	12.53	31
32	Other Health C: Memory Care Coo	562	595	12,437	20.90	32
33	Other(specify) Stock Room	213	213	3,506	16.46	33
34	TOTAL (lines 1 - 33)	390,299	435,478	$ 6,576,815 *	$ 15.10	34

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	587	$ 24,113	1(3)	35
36	Medical Director	Monthly	24,199	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,450	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	3	195	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	590	$ 54,957		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trudy Whittington	Administrator	0	$ 71,069
Sheryl Thomas	Asst. Administrator	0	62,155
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 133,224

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 SCH 21A		408,792
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 408,792

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,457
Unemployment Compensation Insurance	16,099
FICA Taxes	485,244
Employee Health Insurance	1,252,133
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	578,637
Employee Fitness	14,985
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,417,555

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,495
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 59)	705
Patient Background Checks 285	3,420
Misc. Dues & Subscriptions	276
CHNA Dues	1,640
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,536

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,181
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,181

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Hope Creek Care Center
Provider #: 0012252
12/1/2008 to 11/30/2009 **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		209,950
General Management		11,254
Auditor		23,089
Purchasing		5,495
Information Systems		50,398
Treasurer		327
County Board		108,279
Total (agree to Schedule V, line 19, column 8)		408,792

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/08 Ending: 11/30/09

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Hope Creek Care Center **#** 0048694 **Report Period Beginning:** 12/1/08 **Ending:** 11/30/09

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? **Yes**
If YES, give association name and amount. **County Nursing Home Assoc. - $1,640**

(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. $ **57,864** 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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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.