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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 12/01/2011 to 11/30/2012 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) McGladrey 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: 12/01/2011 Ending: 11/30/2012

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	89,670	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	89,670	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	3,789	1,147	10,146	15,082	8
9	SNF/PED					9
10	ICF	50,652	18,716	4	69,372	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,441	19,863	10,150	84,454	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.18%

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 9,424

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: 11/30/2012 Fiscal Year: 11/30/2012

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	792,096	66,020	27,474	885,590		885,590		885,590			1
2	Food Purchase		554,976		554,976		554,976		554,976			2
3	Housekeeping	397,100	52,219	4,600	453,919		453,919		453,919			3
4	Laundry	304,694	39,576		344,270		344,270	(103)	344,167			4
5	Heat and Other Utilities			278,335	278,335		278,335		278,335			5
6	Maintenance	247,880	59,307	70,262	377,449		377,449	(6,489)	370,960			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,741,770	772,098	380,671	2,894,539		2,894,539	(6,592)	2,887,947			8
	B. Health Care and Programs											
9	Medical Director			25,000	25,000		25,000		25,000			9
10	Nursing and Medical Records	6,181,598	(41,116)	841,273	6,981,755		6,981,755		6,981,755			10
10a	Therapy											10a
11	Activities	324,753	8,411	911	334,075		334,075		334,075			11
12	Social Services	123,081	316	215	123,612		123,612		123,612			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	6,629,432	(32,389)	867,399	7,464,442		7,464,442		7,464,442			16
	C. General Administration											
17	Administrative	75,323			75,323		75,323		75,323			17
18	Directors Fees							13,461	13,461			18
19	Professional Services							423,701	423,701			19
20	Dues, Fees, Subscriptions & Promotions			18,445	18,445		18,445		18,445			20
21	Clerical & General Office Expenses	272,372	5,979	164,682	443,033		443,033		443,033			21
22	Employee Benefits & Payroll Taxes			3,231,934	3,231,934		3,231,934	137,591	3,369,525			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,668	10,668		10,668	(554)	10,114			24
25	Other Admin. Staff Transportation			14,179	14,179		14,179		14,179			25
26	Insurance-Prop.Liab.Malpractice			34,506	34,506		34,506		34,506			26
27	Other (specify):*											27
28	**TOTAL General Administration**	347,695	5,979	3,474,414	3,828,088		3,828,088	574,199	4,402,287			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	8,718,897	745,688	4,722,484	14,187,069		14,187,069	567,607	14,754,676			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: 12/01/2011 Ending: 11/30/2012

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			15,559	15,559		15,559	557,499	573,058			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			788,463	788,463		788,463	(8,494)	779,969			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							247	247			34
35	Rent-Equipment & Vehicles			31,188	31,188		31,188		31,188			35
36	Other (specify):*											36
37	TOTAL Ownership			835,210	835,210		835,210	549,252	1,384,462			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	118,657	789,080	1,178,109	2,085,846		2,085,846		2,085,846			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,138	134,138		134,138		134,138			42
43	Other (specify):* Non-Allowable Cos		4,339	831,893	836,232		836,232	(836,232)				43
44	TOTAL Special Cost Centers	118,657	793,419	2,144,140	3,056,216		3,056,216	(836,232)	2,219,984			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,837,554	1,539,107	7,701,834	18,078,495		18,078,495	280,627	18,359,122			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: 12/01/2011 Ending: 11/30/2012

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	(37,437)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(6,489)	6		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	557,499	30		9
10	Interest and Other Investment Income	(8,494)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,322)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(798,131)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (294,374)		$	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)	575,001		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 575,001		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 280,627		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

STATE OF ILLINOIS **Page 5A**

Hope Creek Care Center

ID# 0048694

Report Period Beginning: 12/01/2011

Ending: 11/30/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (25,446)	43	1
2	Offset Transfers to Other Funds	(228,177)	43	2
3	Transfer to Liability Insurance	(62,000)	43	3
4	Principal	(425,000)	43	4
5	Un-supported Travel & Seminar Exp	(554)	24	5
6	Operating Supplies	(1,799)	43	6
7	Professional Services	(53,718)	43	7
8	Communications	(37)	43	8
9	Equipment	(495)	43	9
10	Food Purchases	(723)	43	10
11	Travel	(78)	43	11
12	Miscellaneous	(104)	43	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**	(798,131)		49

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rock Island County	100	Oak Glen Home	Coal Valley	N/A		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Welfare Committee	$	Rock Island County	100.00%	$ 13,461	$ 13,461	1
2	V	19	Risk Management		Rock Island County	100.00%	228,934	228,934	2
3	V	19	General Management		Rock Island County	100.00%	7,083	7,083	3
4	V	19	Auditor		Rock Island County	100.00%	23,126	23,126	4
5	V	19	Information Systems		Rock Island County	100.00%	53,820	53,820	5
6	V	19	Treasurer		Rock Island County	100.00%	303	303	6
7	V	19	County Board		Rock Island County	100.00%	110,436	110,436	7
8	V	22	Worker's Comp		Rock Island County	100.00%	103,085	103,085	8
9	V	22	Unemployment Comp		Rock Island County	100.00%	34,506	34,506	9
10	V	34	County Buildings		Rock Island County	100.00%	247	247	10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 575,001	$ * 575,001	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: 12/01/2011 Ending: 11/30/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STEVE MEERSMAN	CHAIR, NUR HM C	DIRECTOR	0.00	0	1	2.00	SALARY	$ 2,284	18(7)	1
2	STEVE BALLARD	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	2,284	18(7)	2
3	GARY FREEMAN	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	2,284	18(7)	3
4	LAUREN LOFTIN	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	2,284	18(7)	4
5	VIRGIL MAYBERRY	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,442	18(7)	5
6	PATRICK MORENO	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,442	18(7)	6
7	J. ROBERT WESTPFAHL	NURS HM COMM	DIRECTOR	0.00	0	1	2.00	SALARY	1,442	18(7)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,461		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: 12/01/2011 Ending: 1/30/2012

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		228,934		100	228,934	2
3	19	General Management	Cost Allocation Study	100		7,083		100	7,083	3
4	19	Auditor	Cost Allocation Study	100		23,126		100	23,126	4
5	19	Information Systems	Cost Allocation Study	100		53,820		100	53,820	5
6	19	Treasurer	Cost Allocation Study	100		303		100	303	6
7	19	County Board	Cost Allocation Study	100		110,436		100	110,436	7
8	22	Worker's Comp	Actual Cost	100		103,085		100	103,085	8
9	22	Unemployment Comp	Actual Cost	100		34,506		100	34,506	9
10	34	County Buildings	Cost Allocation Study	100		247		100	247	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 571,786	$		$ 571,786	25

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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	$ 8,275,000	6/1/2027	0.0360	$ 368,263	1
2	Bond (2007 Series)		X	Capital Expenditures	Semi-Annual	4/4/07	9,935,000	9,535,000	11/30/2028	0.0400	420,200	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 19,885,000	$ 17,810,000			$ 788,463	9
	B. Non-Facility Related*											
10												10
11									Interest Income Offset		(8,494)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,494)	14
15	TOTALS (line 9+line14)						$ 19,885,000	$ 17,810,000			$ 779,969	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: 12/01/2011 Ending: 11/30/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2011	$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2012 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:			
	2007		8
	2008		9
	2009		10
	2010		11
	2011	N/A	12

County Facility

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hope Creek Care Center COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0048694

CONTACT PERSON REGARDING THIS REPORT Trudy Whittington

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

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

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(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 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 12/01/2011 Ending: 11/30/2012

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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	$ 1,724,686	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Front Lawn Landscaping			2009	4,983		10	498	498	1,743	9
10	Parking Lots			2009	215,420		30	7,181	7,181	25,133	10
11											11
12	Time Clock			2010	13,500		15	900	900	2,250	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	Adjustment to agree to financials					15,559			(15,559)		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: 12/01/2011 Ending: 11/30/2012

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)		$ 19,945,456	$ 15,559		$ 501,343	$ 485,784	$ 1,753,812	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: 12/01/2011 Ending: 11/30/2012

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	$ 713,216	$	$ 61,865	$ 61,865	Various	$ 241,448	71
72	Current Year Purchases	28,309		2,022	2,022	7	2,022	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 741,525	$	$ 63,887	$ 63,887		$ 243,470	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	Ford, Taurus, 2002	2002	15,400				5	15,400	77
78	Patient Care	Chevy Pick-Up, 1993	1993	13,527				5	13,527	78
79	Patient Care	Various (See SCH 13A)		109,536		7,828	7,828	5	95,467	79
80	TOTALS			$ 183,205	$	$ 7,828	$ 7,828		$ 169,136	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)	$ 22,486,712	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,559	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 573,058	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 557,499	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,166,418	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					90
91	TOTALS	$ 888,792	$	$	91

G. Construction-in-Progress

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

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

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

Hope Creek Care Center
Provider #: 0012252
12/01/2011 to 11/30/12

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				5	26,111
Patient Care	Chevy, Minivan, 2003	2003	33,295				5	33,295
Patient Care	Chrysler Town & Country, 2007	2007	21,991		2,200		5	21,991
Patient Care	Ford Focus, 2010	2010	13,123		2,625		5	6,562
Patient Care	Ford Fusion, 2010	2010	15,016		3,003		5	7,508
	Total - Line 79		109,536		7,828			95,467
			To PG 13		**To PG 13**			**To PG 13**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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			247			6
7	TOTAL				$ 247 **			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.	/2013	$
13.	/2014	$
14.	/2015	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 31,188 Description: Nursing Equip $27,561 (Oxygen & Concentrator); Maintenance $23; Misc $170; Wound Care $3,434
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3		hrs	$	5,908	$ 479,062	$ 309	5,908	$ 479,371	1
2	Licensed Speech and Language Development Therapist	L39, C3		hrs		4,807	255,872	165	4,807	256,037	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L39, C1 & C3	5474	hrs	118,657	5,679	443,155	286	11,153	562,098	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				788,320		788,320	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Ambulance	L39, C3					20			20	12
13	Other (specify):										13
14	TOTAL				$ 118,657	16,394	$ 1,178,109	$ 789,080	21,868	$ 2,085,846	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: 12/01/2011 Ending: 11/30/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2012 (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	$ 493,543	$ 493,543	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,498,711)	3,007,955	3,007,955	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	636,000	636,000	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,348	2,348	7
8	Accounts Receivable (owners or related parties)	2,017,272	2,017,272	8
9	Other(specify): Due From Other Govt. Unit	7,490	7,490	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,164,608	$ 6,164,608	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,616,526	13
14	Buildings, at Historical Cost		19,711,553	14
15	Leasehold Improvements, at Historical Cost		233,903	15
16	Equipment, at Historical Cost		924,730	16
17	Accumulated Depreciation (book methods)		(2,166,418)	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			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 20,320,294	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,164,608	$ 26,484,902	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 554,713	$ 554,713	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,970	174,970	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	4,101,896	4,101,896	36
37	See Sch 17A	3,717	3,717	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,835,296	$ 4,835,296	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		17,810,000	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)**	$	$ 17,810,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,835,296	$ 22,645,296	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,329,312	$ 3,839,606	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,164,608	$ 26,484,902	48

*(See instructions.)

Hope Creek Care Center
Provider #: 0012252
12/01/2011 to 11/30/12

Schedule 17A

XV. Balance Sheet

Description	Operating	After Consolidation
Other Current Liabilities - Line 36		
Due From Other Funds	396,850	396,850
Due to other funds - transfers	22,904	22,904
Deferred Revenue	3,682,142	3,682,142
Total - Line 36	4,101,896	4,101,896
Other Current Liabilities - Line 37		
Deposits	400	400
Uncliamed Voucher Checks	2,911	2,911
Unclaimed Payroll Chekcs	406	406
Total - Line 37	3,717	3,717

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 176,093	1
2	Restatements (describe):		2
3	**Prior Period Adjustment - Bond Issue Adjustment**	1,495,020	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,671,113	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(341,801)	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)**	$ (341,801)	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)**	$ 1,329,312	24 *

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,808,528	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,808,528	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	280,378	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 280,378	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	3,552	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	27,877	15
16	Rental of Facility Space	2,025	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	6,489	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	8,448	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 48,391	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,494	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,494	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	**See Sch 19A**	2,590,903	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,590,903	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 17,736,694	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,894,539	31
32	Health Care	7,464,442	32
33	General Administration	3,828,088	33
	B. Capital Expense		
34	Ownership	835,210	34
	C. Ancillary Expense		
35	Special Cost Centers	2,922,078	35
36	Provider Participation Fee	134,138	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 18,078,495	40
41	**Income before Income Taxes (line 30 minus line 40)****	(341,801)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (341,801)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 6,064,574	44
45	Private Pay - Net Inpatient Revenue	555,600	45
46	Medicare - Net Inpatient Revenue	3,254,975	46
47	Other-(specify) **Patient Fees**	2,898,637	47
48	Other-(specify) **IPA Resident Fees**	2,034,742	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 14,808,528	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.**

^ Governmental Entity

Hope Creek Care Center
Provider #: 0012252
12/01/2011 to 11/30/12

Schedule 19A

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

Description	Amount
Transportation Charge	1,364
Transfer from nursing home tax lev	2,265,470
IGT - Intergovernmental transfer fur	238,966
Miscellaneous - Other Revenue	103
Settlement Contra Revenue	85,000
Total - Line 28a	2,590,903

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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	1,848	2,782	$ 71,494	$ 25.70	1
2	Assistant Director of Nursing	1,800	2,867	57,974	20.22	2
3	Registered Nurses	19,693	33,376	619,254	18.55	3
4	Licensed Practical Nurses	66,069	110,000	1,605,030	14.59	4
5	CNAs & Orderlies	217,368	362,521	3,751,365	10.35	5
6	CNA Trainees			-		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,137	5,739	118,657	20.68	8
9	Activity Director	2,080	3,667	38,675	10.55	9
10	Activity Assistants	20,533	33,656	286,078	8.50	10
11	Social Service Workers	5,308	6,568	123,081	18.74	11
12	Dietician					12
13	Food Service Supervisor	7,622	13,843	161,961	11.70	13
14	Head Cook	5,636	10,260	101,691	9.91	14
15	Cook Helpers/Assistants	6,695	12,559	106,749	8.50	15
16	Dishwashers	32,288	49,611	421,695	8.50	16
17	Maintenance Workers	8,115	10,199	247,880	24.30	17
18	Housekeepers	22,455	42,710	397,100	9.30	18
19	Laundry	16,517	34,146	304,694	8.92	19
20	Administrator	1,756	2,147	75,323	35.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,795	14,252	272,372	19.11	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	1,794	1,989	32,229	16.20	31
32	Other Health C: Memory Care Coo	1,756	3,140	44,252	14.09	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	454,265	756,032	$ 8,837,554 *	$ 11.69	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	$ 27,474	1(3)	35
36	Medical Director	Monthly	25,000	9(3)	36
37	Medical Records Consultant	Monthly	5,695	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,237	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	911	11(3)	44
45	Social Service Consultant	Monthly	215	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 75,532		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,127	$ 46,596	10(3)	50
51	Licensed Practical Nurses	5,569	224,079	10(3)	51
52	Certified Nurse Assistants/Aides	17,922	548,666	10(3)	52
53	TOTAL (lines 50 - 52)	24,618	$ 819,341		53

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trudy Whittington	Administrator	0	$ 75,323
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,323

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

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,085
Unemployment Compensation Insurance	34,506
FICA Taxes	653,014
Employee Health Insurance	1,517,829
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	988,053
Uniform Clothing	56,247
Other Employee Benefits	16,791
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,369,525

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 37)	1,100
Patient Background Checks 302	3,192
Publishing	3,763
Miscellaneous Dues & Subscriptions	10,390
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,445

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,114
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,114

**See instructions.

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/01/2011 Ending: 11/30/2012

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

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

Facility Name & ID Number Hope Creek Care Center **#** 0048694 **Report Period Beginning:** 12/01/2011 **Ending:** 11/30/2012

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? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **65,221** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **134,138**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey 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.