RSM US LLP

To the Board of Directors
Hope Creek Care Center
East Moline, Illinois

We have prepared the Medicaid Cost Report Financial and Statistical Report for Long-Term Care Facilities for Hope Creek Care Center for the period ending November 30, 2019 included in the accompanying prescribed form in accordance with the requirements of the State of Illinois Department of Healthcare and Family Service.

While cost report preparation involves assembly of information in a financial statement format, that information is solely for cost report purposes and should not be used for any other purpose. Management is responsible for the representations contained in the cost report and should review the cost report thoroughly before signing and submitting.

The cost report is subject to review by the Bureau of Health Finance and others with oversight responsibility. Professional judgment is used in resolving questions where the cost report and reimbursement rules and regulations are unclear. The Bureau of Health Finance and other reviewers may choose to interpret rules and regulations differently than what was reflected in the as filed cost report. As a result of these reviews, adjustments to the cost report may be proposed which could have an adverse effect on the cost report settlement.

RSM US LLP

Schaumburg, Illinois
April 13, 2020

		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.

2019
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2019)

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: 366006649010

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: amanda.springborn@rsmus.com

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2018 to 11/30/2019 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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	33,343	12,472	7,324	53,139	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,343	12,472	7,324	53,139	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.42%

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

N/A (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

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

YES [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

I. On what date did you start providing long term care at this location?

Date started 9/1/1972

J. Was the facility purchased or leased after January 1, 1978?

YES [ ] Date NO [X]

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

YES [X] NO [ ] If YES, enter number of beds certified 245 and days of care provided 2,264

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: 11/30/2019 Fiscal Year: 11/30/2019

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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	608,620	54,129	25,644	688,393		688,393	-	688,393			1
2	Food Purchase		382,839		382,839		382,839	(7,782)	375,057			2
3	Housekeeping	272,905	40,503	3,905	317,313		317,313	-	317,313			3
4	Laundry	246,181	11,634	-	257,815		257,815	-	257,815			4
5	Heat and Other Utilities			259,592	259,592		259,592	-	259,592			5
6	Maintenance	186,590	46,915	98,723	332,228		332,228	-	332,228			6
7	Other (specify):*	-	-	-				-				7
8	**TOTAL General Services**	1,314,296	536,020	387,864	2,238,180		2,238,180	(7,782)	2,230,398			8
	B. Health Care and Programs											
9	Medical Director	-	-	-				30,000	30,000			9
10	Nursing and Medical Records	4,340,749	167,314	1,364,899	5,872,962		5,872,962	(35,971)	5,836,991			10
10a	Therapy	178,467	-	-	178,467		178,467	-	178,467			10a
11	Activities	311,996	1,577	387	313,960		313,960	-	313,960			11
12	Social Services	155,876	-	-	155,876		155,876	(41,872)	114,004			12
13	CNA Training	-	-	-				-				13
14	Program Transportation	-	-	-				-				14
15	Other (specify):*	-	-	-				-				15
16	**TOTAL Health Care and Programs**	4,987,088	168,891	1,365,286	6,521,265		6,521,265	(47,843)	6,473,422			16
	C. General Administration											
17	Administrative	-	-	-				103,024	103,024			17
18	Directors Fees			-				12,326	12,326			18
19	Professional Services			-				431,194	431,194			19
20	Dues, Fees, Subscriptions & Promotions			5,723	5,723		5,723	-	5,723			20
21	Clerical & General Office Expenses	407,158	8,980	296,298	712,436		712,436	(164,826)	547,610			21
22	Employee Benefits & Payroll Taxes			1,799,558	1,799,558		1,799,558	1,498,055	3,297,613			22
23	Inservice Training & Education			-				-				23
24	Travel and Seminar			6,512	6,512		6,512	-	6,512			24
25	Other Admin. Staff Transportation		-	4,064	4,064		4,064	-	4,064			25
26	Insurance-Prop.Liab.Malpractice			22,069	22,069		22,069	-	22,069			26
27	Other (specify):*			-				-				27
28	**TOTAL General Administration**	407,158	8,980	2,134,224	2,550,362		2,550,362	1,879,773	4,430,135			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,708,542	713,891	3,887,374	11,309,807		11,309,807	1,824,148	13,133,955			29

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

Facility Name & ID Number Hope Creek Care Center #0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			-				561,271	561,271			30
31	Amortization of Pre-Op. & Org.			-				-				31
32	Interest			464,750	464,750		464,750	(7,956)	456,794			32
33	Real Estate Taxes			-				-				33
34	Rent-Facility & Grounds			-				258	258			34
35	Rent-Equipment & Vehicles			6,085	6,085		6,085	-	6,085			35
36	Other (specify):*			-				-				36
37	**TOTAL Ownership**			470,835	470,835		470,835	553,573	1,024,408			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-				-				38
39	Ancillary Service Centers	-	253,100	560,016	813,116		813,116	-	813,116			39
40	Barber and Beauty Shops	-	-	-				-				40
41	Coffee and Gift Shops	-	-	-				-				41
42	Provider Participation Fee			-				442,949	442,949			42
43	Other (specify):* Non-Allowable Cos	-	6,523	1,213,838	1,220,361		1,220,361	(1,220,361)				43
44	**TOTAL Special Cost Centers**		259,623	1,773,854	2,033,477		2,033,477	(777,412)	1,256,065			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,708,542	973,514	6,132,063	13,814,119		13,814,119	1,600,309	15,414,428			45

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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	(7,781)	2		4
5	Telephone, TV & Radio in Resident Rooms	(30,512)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(5,971)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	561,271	30		9
10	Interest and Other Investment Income	(7,956)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(789,949)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (280,898)		$	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)	1,881,207		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,881,207		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,600,309		37

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

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

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

Hope Creek Care Center

ID# 0048694

Report Period Beginning: 12/1/2018

Ending: 11/30/2019

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs - Part A	$ (9,426)	43	1
2	Principal	(1,170,000)	43	2
3	Operating Supplies	(265)	43	3
4	Professional Services	(3,900)	43	4
5	Reclass Provider Bed Tax	442,949	42	5
6	Misc Income	(1,177)	21	6
7	Publishing	(5,955)	43	7
8	Food Purchases	(303)	43	8
9	Admissions Coordinator Salary	(41,872)	12	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**	(789,949)		49

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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	N/A		N/A		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Welfare Committee	$	Rock Island County	100.00	$ 12,326	$ 12,326	1
2	V	19	Risk Management		Rock Island County	100.00	229,243	229,243	2
3	V	19	General Management		Rock Island County	100.00	12,612	12,612	3
4	V	19	Auditor		Rock Island County	100.00	23,111	23,111	4
5	V	19	Information Systems		Rock Island County	100.00	46,844	46,844	5
6	V	19	Treasurer		Rock Island County	100.00	295	295	6
7	V	19	County Board		Rock Island County	100.00	58,463	58,463	7
8	V	22	Worker's Comp		Rock Island County	100.00	86,255	86,255	8
9	V	22	FICA		Rock Island County	100.00	533,855	533,855	9
10	V	22	IMRF		Rock Island County	100.00	877,945	877,945	10
11	V	34	County Buildings		Rock Island County	100.00	258	258	11
12	V								12
13	V								13
14	Total			$			$ 1,881,207	$ * 1,881,207	14

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

VII. RELATED PARTIES

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

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jessey Hullon	CHAIR, NUR HM C	DIRECTOR	0.00%	0	1	2.00	Salary	$ 3,582	18(7)	1
2	Michael Kelly	NURS HM COMM	DIRECTOR	0.00%	0	1	2.00	Salary	1,457	18(7)	2
3	Ginny Shelton	NURS HM COMM	DIRECTOR	0.00%	0	1	2.00	Salary	1,457	18(7)	3
4	Rod Simmer	NURS HM COMM	DIRECTOR	0.00%	0	1	2.00	Salary	1,457	18(7)	4
5	Carol Near	NURS HM COMM	DIRECTOR	0.00%	0	1	2.00	Salary	1,457	18(7)	5
6	Tim Erno	NURS HM COMM	DIRECTOR	0.00%	0	1	2.00	Salary	1,457	18(7)	6
7	Bryon Tyson	NURS HM COMM	DIRECTOR	0.00%	0	1	2.00	Salary	1,457	18(7)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 12,324		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: 12/1/2018 Ending: 1/30/2019

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Welfare Committee	Cost Allocation Study	1		$ 12,326	$ 12,326	1	$ 12,326	1
2	19	Risk Management	Cost Allocation Study	1		229,243		1	229,243	2
3	19	General Management	Cost Allocation Study	1		12,612		1	12,612	3
4	19	Auditor	Cost Allocation Study	1		23,111		1	23,111	4
5	19	Information Systems	Cost Allocation Study	1		46,844		1	46,844	5
6	19	Treasurer	Cost Allocation Study	1		295		1	295	6
7	19	County Board	Cost Allocation Study	1		58,463		1	58,463	7
8	22	Worker's Comp	Cost Allocation Study	1		86,255		1	86,255	8
9	22	FICA	Cost Allocation Study	1		533,855		1	533,855	9
10	22	IMRF	Cost Allocation Study	1		877,945		1	877,945	10
11	34	County Buildings	Cost Allocation Study	1		258		1	258	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					$ 1,881,207	$ 12,326		$ 1,881,207	25

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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 (2013 Series)		X	Capital Expenditures	Semi-Annual	5/9/2013	$ 3,700,000	$ 3,380,000	12/1/2024	0.0200	$ 86,326	1
2	Bond (2016 Series)		X	Capital Expenditures	Semi-Annual	9/27/2016	9,105,000	8,825,000	12/1/2027	0.0200	372,666	2
3												3
4												4
5												5
	Working Capital											
6	Tax Anticipation Warrants		X	Working Capital	No	1/29/2018	750,000	-	1/31/2019	0.0250	5,758	6
7												7
8												8
9	TOTAL Facility Related						$ 13,555,000	$ 12,205,000			$ 464,750	9
	B. Non-Facility Related*											
10												10
11								Interest Income			(7,956)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,956)	14
15	TOTALS (line 9+line14)						$ 13,555,000	$ 12,205,000			$ 456,794	15

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

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

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

Facility Name & ID Number Hope Creek Care Center **#** 0048694 **Report Period Beginning:** 12/1/2018 **Ending:** 11/30/2019

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2018 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.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2019 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	**Alloc. Fr. Mgmt. Co.**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2014	N/A	8
	2015		9
	2016		10
	2017		11
	2018		12

County Facility-Exempt from real estate taxes

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2018	$	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.

2018 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 Diane Helms

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

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

Enter the tax index number and real estate tax assessed for 2018 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 2018.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES N/A NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2018 tax bills which were listed in Section A to this statement. Be sure to use the 2018 tax bill which is normally paid during 2019.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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	$ 5,174,034	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Front Lawn Landscaping			2009	4,983		10	252	252	4,983	9
10	Parking Lots			2009	215,420		30	7,181	7,181	75,400	10
11								-			11
12	Time Clock			2010	13,500		15	900	900	8,550	12
13								-			13
14	Trane Furnace & AC in HCC Annex Bldg			2014	6,724		10	672	672	3,698	14
15								-			15
16	Picnic Pavilion			2015	157,830		20	7,892	7,892	35,512	16
17	2 Thermostats - Rooftop Unit 12 on Building 5			2015	2,645		10	265	265	1,190	17
18								-			18
19	Carpet - Dining Room			2016	17,557		10	1,756	1,756	7,024	19
20								-			20
21	Paint Exterior Red Siding Panels - Outside of Building			2019	19,875		10	993.75	994	994	21
22								-			22
23								-			23
24								-			24
25								-			25
26								-			26
27								-			27
28								-			28
29								-			29
30								-			30
31								-			31
32								-			32
33								-			33
34								-			34
35								-			35
36								-			36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$ -		$ -	$	$	37
38				-		-			38
39				-		-			39
40				-		-			40
41				-		-			41
42				-		-			42
43				-		-			43
44				-		-			44
45				-		-			45
46				-		-			46
47				-		-			47
48				-		-			48
49				-		-			49
50				-		-			50
51				-		-			51
52				-		-			52
53				-		-			53
54				-		-			54
55				-		-			55
56				-		-			56
57				-		-			57
58				-		-			58
59				-		-			59
60				-		-			60
61				-		-			61
62				-		-			62
63				-		-			63
64				-		-			64
65				-		-			65
66				-		-			66
67				-		-			67
68				-		-			68
69				-		-			69
70	TOTAL (lines 4 thru 69)		$ 20,150,087	$		$ 512,675	$ 512,675	$ 5,311,385	70

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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	$ 308,794	$	$ 40,359	$ 40,359	7	$ 273,339	71
72	Current Year Purchases	5,276		1,055	1,055	5	1,055	72
73	Fully Depreciated Assets	434,321					434,321	73
74								74
75	TOTALS	$ 748,391	$ -	$ 41,414	$ 41,414		$ 708,715	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Ford, Diesel Bus, 1994	1994	$ 44,742	$ -	$ -	$	5	$ 44,742	76
77	Patient Care	Chevy Pick-Up, 1993	1993	13,527	-	-		5	13,527	77
78	Patient Care	Chevy, Truck, 2002	2001	26,111	-	-		5	26,111	78
79	Patient Care	Various (See SCH 13A)		106,210	-	7,182	7,182	5	85,863	79
80	TOTALS			$ 190,590	$	$ 7,182	$ 7,182		$ 170,243	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)	$ 22,705,594	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)	$ 561,271	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 561,271	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,190,343	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building - 1948	$ 8,412	$	$	86
87	Building - 1950	5,174			87
88	Building - 1954	339,336			88
89	Building - 1967	535,870			89
90	Vehicles - 2002 & 2010	28,523			90
91	TOTALS	$ 917,315	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2019**

Schedule 13A

XI. Ownership Costs
Line 79 - Vehicle Depreciation

Use	Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Patient Care	Chevy, Minivan	2003	33,295			-	5	33,295
Patient Care	Chrysler Town	2007	21,991			-	5	21,991
Patient Care	Ford Fusion 2010	2010	15,016			-	5	15,016
Patient Care	Grand Caravan	2017	35,908		7,182	-	5	15,561
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			**106,210**	-	**7,182**	-		**85,863**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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			258			6
7	TOTAL				$ 258 **			7

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

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2020	$
13.	/2021	$
14.	/2022	$

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: $ 6,085 Description: See Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2019**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Oxygen, Mattress & Concentrator	$ 5,265
Maintenance Equipment	$ 620
Booth Rental	$ 200
Total - Line 16	**$ 6,085**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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.

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	$	3,149	$ 206,653	$	3,149	$ 206,653	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,612	103,344		1,612	103,344	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		4,435	250,019		4,435	250,019	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				235,167		235,167	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					17,933		17,933	12
13	Other (specify):									13
14	TOTAL			$	9,196	$ 560,016	$ 253,100	9,196	$ 813,116	14

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

STATE OF ILLINOIS

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/2019 (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	$ 6,548	$ 6,548	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 570,420)	1,556,202	1,556,202	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	598,000	598,000	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,969	1,969	7
8	Accounts Receivable (owners or related parties)	688,961	688,961	8
9	Other(specify): See Sch 17A	31,899	31,899	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,883,579	$ 2,883,579	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		438,534	15
16	Equipment, at Historical Cost		938,981	16
17	Accumulated Depreciation (book methods)		(6,190,343)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 16,515,251	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,883,579	$ 19,398,830	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,449,780	$ 1,449,780	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	302,060	302,060	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	6,485,557	6,485,557	36
37	See Sch 17A	4,460	4,460	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,241,857	$ 8,241,857	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		12,205,000	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)**	$	$ 12,205,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,241,857	$ 20,446,857	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,358,278)	$ (1,048,027)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,883,579	$ 19,398,830	48

*(See instructions.)

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2019**

Schedule 17A

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

	Description	Operating	After Consolidation
108-00-00-11550	SRF02 A/R NSF Checks	30,974	30,974
108-00-00-13500	SRF02 Int. Rec. on Investments	925	925
	Total - Line 9	**31,899**	**31,899**

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

	Description	Operating	After Consolidation
108-00-00-11701	SRF02 Est. Uncoll. Due From	631,154	631,154
108-00-00-20700	SRF02 Due Other Funds	3,357,268	3,357,268
108-00-00-21810	SRF02 Revenue anticipation loan payable	1,900,000	1,900,000
108-00-00-22320	SRF02 Deferred Revenue	597,135	597,135
	Total - Line 36	**6,485,557**	**6,485,557**

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

	Description	Operating	Consolidation
108-00-00-22000	SRF02 Deposits	400	400
108-00-00-22150	SRF02 Unclaimed Voucher Checks	2,911	2,911
108-00-00-22151	SRF02 Unclaimed Payroll Checks	1,149	1,149
	Total - Line 36	**4,460**	**4,460**

Facility Name & ID Number Hope Creek Care Center **#** 0048694 **Report Period Beginning:** 12/1/2018 **Ending:** 11/30/2019

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,901,391)	1
2	Restatements (describe):		2
3	**Prior period adjustment**	(184,812)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,086,203)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,272,075)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,272,075)	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)**	$ (5,358,278)	24 *

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,104,124	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,104,124	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	82,175	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 82,175	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,782	14
15	Telephone, Television and Radio	8,118	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	5,971	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	277	21
22	Laundry	2,981	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 25,129	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,956	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,956	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a	See Sch 19A	2,322,660	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,322,660	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,542,044	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,238,180	31
32	Health Care	6,521,265	32
33	General Administration	2,550,362	33
	B. Capital Expense		
34	Ownership	470,835	34
	C. Ancillary Expense		
35	Special Cost Centers	2,033,477	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,814,119	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,272,075)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,272,075)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,307,986	44
45	Private Pay - Net Inpatient Revenue	72,201	45
46	Medicare - Net Inpatient Revenue	1,525,887	46
47	Other-(specify) Patient Fees	2,365,367	47
48	Other-(specify) Veterans	832,683	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,104,124	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No^ If not, please attach a reconciliation.**

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

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

^Entity is a cash basis taxpayer.

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2019**

Schedule 19A

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

	Description		Amount
108-21-00-33563	SRF02 IGT- Inter governmental transfer funds	$	621,646
108-21-00-34634	SRF02 Transportation charge	$	1,562
108-21-00-34636	CPR Training fees	$	4,160
108-21-00-36993	Refunds/rebates for prior years	$	2,450
108-21-00-36994	SRF02 Miscellaneous - other revenue	$	5,037
108-21-00-39135	SRF02 Transfer from nurse home taxlevy	$	2,646,237
108-21-00-39211	SRF02 Sales of junk or salvage value	$	94
108-21-10-99100	Transfer to General Fund	$	(694,134)
108-21-10-99112	SRF02 Transfer to Other Agencies	$	(264,392)
108-21-10-99120	SRF02 Transfer of Medicare cost overpayment p	$	-
	Total - Line 28	**$**	**2,322,660**

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

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	1,328	1,556	$ 63,963	$ 41.11	1
2	Assistant Director of Nursing	1,141	1,324	48,170	36.38	2
3	Registered Nurses	11,219	14,782	408,488	27.63	3
4	Licensed Practical Nurses	41,282	49,731	1,090,083	21.92	4
5	CNAs & Orderlies	148,259	172,793	2,622,413	15.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,625	9,306	178,467	19.18	8
9	Activity Director	1,968	2,080	53,269	25.61	9
10	Activity Assistants	16,497	17,623	258,727	14.68	10
11	Social Service Workers	4,734	5,272	114,004	21.62	11
12	Dietician					12
13	Food Service Supervisor	1,834	2,378	59,647	25.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,017	40,084	548,973	13.70	15
16	Dishwashers					16
17	Maintenance Workers	8,430	10,072	186,590	18.53	17
18	Housekeepers	16,808	19,124	272,905	14.27	18
19	Laundry	13,015	15,718	246,181	15.66	19
20	Administrator	456	745	39,508	53.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,814	15,061	367,650	24.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca See Sch 20A	4,764	5,274	107,632	20.41	32
33	Other(specify) Admissions	1,785	2,128	41,872	19.68	33
34	TOTAL (lines 1 - 33)	330,976	385,051	$ 6,708,542 *	$ 17.42	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	$ 25,644	1(3)	35
36	Medical Director	Monthly	30,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,621	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	387	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 58,652		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7,695	$ 367,722	10(3)	50
51	Licensed Practical Nurses	14,919	613,880	10(3)	51
52	Certified Nurse Assistants/Aides	12,753	350,676	10(3)	52
53	TOTAL (lines 50 - 52)	35,367	$ 1,332,278		53

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2019**

Schedule 20A

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

Description	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries	Average Hourly Wage
MDS Reimbursement Manager	1,614	1,706	35,254	$ 20.66
Central Supply Clerk	1,593	1,856	35,132	$ 18.93
Memory Care Coordinator	1,557	1,712	37,246	$ 21.76
Total - Line 32 Other Health Care (specify):	**4,764**	**5,274**	**107,632**	

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2018 Ending: 11/30/2019

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

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

B. Administrative - Other

Description	Amount
See Schedule 21A	$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

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

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,255
Unemployment Compensation Insurance	
FICA Taxes	533,855
Employee Health Insurance	1,476,002
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	877,945
Uniform Clothing	38,632
Other Employee Benefits	284,924
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,297,613

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 22)	753
Patient Background Checks 257	2,890
Publishing	1,056
Miscellaneous Dues & Subscriptions	1,024
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,723

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,512
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,512

**See instructions.

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2019**

Schedule 21A

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership	Amount
Cassandra Baker	Administrator	0%	$ 39,508
Total (agree to Schedule V, line 17, column 7)			$ 39,508

B. Administrative Other

Name	Function	Amount
R.A. Mills	Int. Administrator	$ 9,292
Roger Herman	Int. Administrator	$ 35,513
Trudi Whittington	Int. Administrator	$ 18,711
Total (agree to Schedule V, line 17, column 7)		$ 63,516

Facility Name: **Hope Creek Care Center**
IDPH License ID Number: **0048694**
Fiscal Year End: **11/30/2019**

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
	Total (agree to Schedule V, line 19, column 3)	-
Allocated from County	Auditor	23,111
Allocated from County	County Board	58,463
Allocated from County	General Management	12,612
Allocated from County	Information System	46,844
Allocated from County	Risk Management	229,243
Allocated from County	Treasurer	295
RSM US LLP	Accounting	8,126
Honkamp Krueger & Co.	Accounting	52,500
	Total (agree to Schedule V, line 19, column 8)	431,194

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? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,724** 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. $ **442,949**
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. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,782**

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

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees.

Rock Island County Illinois
Year End: November 30, 2019
Medicaid Adjustments
Date: 12/1/2018 To 11/30/2019

MCD B

Prepared by 1	Prepared by 2	Prepared by 3	In-Chrg Review
SB112 4/5/2020			
Manager Review	**Partner Review**	**Reviewed by 4**	**Reviewed by 5**
AS23 4/13/2020			

Number	Date	Name	Account No	Reference	Tax Link	Annotation	Debit	Credit	Recurrence	Misstatement
MCD 1	11/30/2019	Adjustments to P/L	9999 SRF02				1,220,361.00			
MCD 1	11/30/2019	Cable for Residents	108-21-10-632CB SRF02					20,057.00		
MCD 1	11/30/2019	Phone Svc. Residents	108-21-10-632PH SRF02					10,455.00		
MCD 1	11/30/2019	Bad debt expenses	108-21-10-65100 SRF02							
MCD 1	11/30/2019	Principal	108-21-10-87100 SRF02					1,170,000.00		
MCD 1	11/30/2019	Salaries and wages	108-21-15-41100 SRF02							
MCD 1	11/30/2019	Office Supplies	108-21-15-52100 SRF02							
MCD 1	11/30/2019	Operating Supplies	108-21-15-52200 SRF02					265.00		
MCD 1	11/30/2019	Food Purchases	108-21-15-52600 SRF02					303.00		
MCD 1	11/30/2019	Professional Services	108-21-15-63100 SRF02					3,900.00		
MCD 1	11/30/2019	Communications	108-21-15-63200 SRF02							
MCD 1	11/30/2019	Publishing	108-21-15-63400 SRF02					5,955.00		
MCD 1	11/30/2019	Dues & memberships	108-21-15-64200 SRF02							
MCD 1	11/30/2019	Lab	108-21-41-631LA SRF02					9,426.00		
MCD 1	11/30/2019	Dues & memberships	108-21-41-64200 SRF02							
		To remove non-allowable costs. SB 3/22/20							Recurring	
MCD 2	11/30/2019	Medical supplies	108-21-00-34631 SRF02				56.00			
MCD 2	11/30/2019	Diapers	108-21-00-34633 SRF02				5,915.00			
MCD 2	11/30/2019	Guest Meals	108-21-00-34637 SRF02				7,782.00			
MCD 2	11/30/2019	Investment earnings	108-21-00-36110 SRF02				7,956.00			
MCD 2	11/30/2019	Miscellaneous - other revenue	108-21-00-36994 SRF02				1,177.00			
MCD 2	11/30/2019	Printing & Duplicating	108-21-10-63500 SRF02					1,177.00		
MCD 2	11/30/2019	Interest	108-21-10-87200 SRF02					7,956.00		
MCD 2	11/30/2019	Operating Supplies	108-21-41-52200 SRF02					5,971.00		
MCD 2	11/30/2019	Underpads	108-21-41-522UP SRF02							
MCD 2	11/30/2019	Food Purchases	108-21-42-52600 SRF02					7,782.00		
		To offset income against expense. SB 3/22/20							Recurring	
MCD 3	11/30/2019	Adjustments to P/L	9999 SRF02					1,881,208.00		
MCD 3	11/30/2019	Benefits - WC & Unemployment	63110 SRF02				86,255.00			
MCD 3	11/30/2019	Welfare Board Member	63111 SRF02				12,326.00			
MCD 3	11/30/2019	County Building Alloc	63112 SRF02				258.00			
MCD 3	11/30/2019	County Prof Fees	63113 SRF02				370,569.00			
MCD 3	11/30/2019	FICA/Medicare	108-21-10-41310 SRF02				533,855.00			
MCD 3	11/30/2019	IMRF	108-21-10-41320 SRF02				877,945.00			
		To adjust to bring in county costs. SB 3/29/20							Recurring	
MCD 4	11/30/2019	Adjustment to BS	2999 SRF02				12,205,000.00			
MCD 4	11/30/2019	2006 Bond Payable	20000 SRF02							
MCD 4	11/30/2019	2013 Bond Payable	20020 SRF02					3,380,000.00		
MCD 4	11/30/2019	2016 Bond Payable	20030 SRF02					8,825,000.00		
		To set up liability accounts for the 2006,2007,2013 and 2016 bonds. LC SB 3/29/20							Recurring	
MCD 7	11/30/2019	Professional Services	64400 SRF02				60,625.00			
MCD 7	11/30/2019	Professional Services	64400 SRF02							
MCD 7	11/30/2019	Professional Services	108-21-10-63100 SRF02					8,125.00		
MCD 7	11/30/2019	Outside Contractual	108-21-10-64400 SRF02					52,500.00		
MCD 7	11/30/2019	Outside Contractual	108-21-10-64400 SRF02							
		To adjust Accounting Fees to proper account. SB 3/29/20							Recurring	
MCD 8	11/30/2019	IL Provider Bed Tax	76601 SRF02				442,949.00			
MCD 8	11/30/2019	Public aid medicaid	108-21-00-33561 SRF02					442,949.00		
		To reclass bed tax to the appropriate account. SB 3/22/20							Recurring	
MCD 9	11/30/2019	Adjustments to P/L	9999 SRF02				41,872.00			
MCD 9	11/30/2019	Salaries and wages	108-21-89-41100 SRF02					41,872.00		
		To remove admission coordinator salary. SB 4/05/20							Recurring	
MCD 10	11/30/2019	Administrator Salaries	41101 SRF02				39,508.00			
MCD 10	11/30/2019	Outside Contractual	108-21-10-64400 SRF02					39,508.00		
		To reclass administrator salary from clerical line to administrator line. SB 4/05/20							Recurring	
MCD 11	11/30/2019	Adjustment to BS	2999 SRF02	PG 11-13				22,705,594.00		
MCD 11	11/30/2019	Adjustment to BS	2999 SRF02	PG 11-13			6,190,343.00			

Prepared by 1	Prepared by 2	Prepared by 3	In-Chrg Review
SB112 4/5/2020			
Manager Review	**Partner Review**	**Reviewed by 4**	**Reviewed by 5**
AS23 4/13/2020			

Number	Date	Name	Account No	Reference	Tax Link	Annotation	Debit	Credit	Recurrence	Misstatement
MCD 11	11/30/2019	Depreciation	9998 SRF02	PG 11-13			561,271.00			
MCD 11	11/30/2019	Adjustments to P/L	9999 SRF02	PG 11-13				561,271.00		
MCD 11	11/30/2019	Building Cost	15101 SRF02	PG 11-13			19,711,553.00			
MCD 11	11/30/2019	Land Cost	15102 SRF02	PG 11-13			1,616,526.00			
MCD 11	11/30/2019	Building Improv. Cost	15103 SRF02	PG 11-13			438,534.00			
MCD 11	11/30/2019	Equip. Cost	15104 SRF02	PG 11-13			748,391.00			
MCD 11	11/30/2019	Vehicle Cost	15105 SRF02	PG 11-13			190,590.00			
MCD 11	11/30/2019	Building Accum. Depre	15106 SRF02	PG 11-13				5,174,034.00		
MCD 11	11/30/2019	Building Improv. Accum. Depre	15107 SRF02	PG 11-13				137,351.00		
MCD 11	11/30/2019	Equip. Accum. Depre	15108 SRF02	PG 11-13				708,715.00		
MCD 11	11/30/2019	Vehicle Accum. Depre	15109 SRF02	PG 11-13				170,243.00		
		To adjust to bring in fixed assets. SB 3/29/20								
MCD 12	11/30/2019	Med Director Fees	63200 SRF02				30,000.00			
MCD 12	11/30/2019	Professional Services	108-21-41-63100 SRF02					30,000.00		
		To reclass Medical Director to correct account. SB 3.29.20							Recurring	
MCD 13	11/30/2019	Contracted Administrator Wages	41102 SRF02	21B			63,516.00			
MCD 13	11/30/2019	Outside Contractual	108-21-10-64400 SRF02	21B				63,516.00		
		To Reclass Contracted Administrator expenses. SB 4/05/20								
							45,465,133.00	**45,465,133.00**		

Net Income (Loss) **(11,398,769.00)**

Final Notice of Illinois Municipal Retirement Fund Contribution Rate for Calendar Year 2019

Date November 2018

Employer name ROCK ISLAND COUNTY Employer No. 03058

The contribution rates on earnings paid by your participating governmental unit to IMRF members are shown below. The Illinois Pension Code provides that the employer is responsible for remitting both employer and member contributions to IMRF along with the related deposit report according to prescribed due dates.

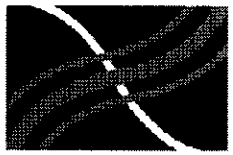
IMRF contributions must be paid on the earnings of all employees working in participating positions. Your employer contribution rate on member earnings is based upon actuarial costs for retirement, supplemental retirement, death, and disability benefits. The actuarial formula is specified in the Illinois Pension Code. Member contributions are specified in the Illinois Pension Code and help to meet the cost of future retirement benefits.

Participating governmental units with taxing powers are authorized by the Illinois Pension Code to levy a special IMRF tax for payment of employer IMRF contributions. However, this levy may be used only for employer payments. It may not be used for payment of IMRF member contributions. These must be paid out of the same fund from which the employee IMRF earnings are paid. Interest charges are assessed on any late payments. Refer to Section 4 of the IMRF Manual for Authorized Agents for interest charge procedures. If you have any questions, please contact the IMRF Employer Account Analyst at 1-800-ASK-IMRF.

Brian Collins, Executive Director

	IMRF Contributions		
	Regular	**SLEP**	**ECO**
Member Contributions (tax-deferred)	4.50%	7.50%	7.50%
Employer Contributions			
• **Retirement Rate**			
Normal Cost	5.49%	11.01%	13.21%
Funding Adjustment <over> under	3.09%	5.73%	115.05%
Net Retirement Rate	8.58%	16.74%	128.26%
• **Other Program Benefits**			
Death	0.06%	0.06%	0.06%
Disability	0.08%	0.08%	0.08%
Supplemental Benefit Payment	0.62%	0.62%	0.62%
Early Retirement Incentive	3.90%	2.93%	0.00%
SLEP Enhancement	0.00%	3.55%	0.00%
• **TOTAL EMPLOYER RATE**	13.24%	23.98%	129.02%

ROCK ISLAND COUNTY
KENNETH E. MARANDA, INTERIM COUNTY BOARD CHAIRMAN
1504 3RD AVE
ROCK ISLAND COUNTY BOARD OFFIC
ROCK ISLAND IL 61201-8612

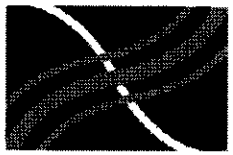


Rock Island County

Accounts Payable by G/L Distribution Report

Invoice Date Range 12/01/18 - 11/30/19

Vendor	Invoice No.	Invoice Description	Status	Held Reason	Invoice Date	Due Date	G/L Date	Received Date	Payment Date	Invoice Amount
Fund **108 - Hope Creek**										
Department **21 - Hope Creek**										
Sub Department **10 - Administration**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	132325	Tri State Fire;Fire Extitg training;2/5/19;4522-6503	Paid by Check # 67935		02/19/2019	02/19/2019	02/19/2019		03/22/2019	1,000.00
104890 - FIRST MIDWEST BANK	2054949	AHA Coding Hndbk;8/27/19;4529-1127	Paid by Check # 69873		09/23/2019	09/23/2019	09/23/2019		10/18/2019	20.00
104890 - FIRST MIDWEST BANK	2054950	Aha Coding Hndbk;8/27/19;4529-1127	Paid by Check # 69873		09/23/2019	09/23/2019	09/23/2019		10/18/2019	20.00
			Object detail **630.00 - Training & Education** Totals				Invoice Transactions 3			$1,040.00
			Sub Department **10 - Administration** Totals				Invoice Transactions 3			$1,040.00
Sub Department **18 - Facilities/Maintenance**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	23735	Eastern IA College;Disaster Confrence;3/27/19;4522-6503	Paid by Check # 68698		04/23/2019	04/23/2019	04/23/2019		05/24/2019	40.00
103616 - _TRI STATE FIRE CONTROL	138100	Tri State Fire Control;HOFT;10/25/19	Paid by EFT # 2031		11/05/2019	11/05/2019	11/05/2019		12/20/2019	1,000.00
			Object detail **630.00 - Training & Education** Totals				Invoice Transactions 2			$1,040.00
			Sub Department **18 - Facilities/Maintenance** Totals				Invoice Transactions 2			$1,040.00
Sub Department **41 - Patient Care**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	26786246	ARC;CPR Training/Friendship Manor;12/14/18;4527-9726	Paid by Check # 67696		01/17/2019	01/17/2019	01/17/2019		02/22/2019	100.00
104890 - FIRST MIDWEST BANK	26891987	ARC;CPR Training/Friendship Manor;12/22/18;4527-9726	Paid by Check # 67696		01/17/2019	01/17/2019	01/17/2019		02/22/2019	180.00
104890 - FIRST MIDWEST BANK	26944266	ARC;CPR Training;12/28/18;4527-9726	Paid by Check # 67696		01/17/2019	01/17/2019	01/17/2019		02/22/2019	160.00
104890 - FIRST MIDWEST BANK	27049415	ARC;CPR Training/Friendship Manor;1/4/19;4527-9726	Paid by Check # 67696		01/17/2019	01/17/2019	01/17/2019		02/22/2019	198.00

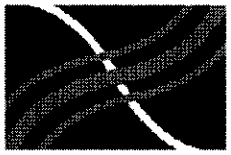


Rock Island County

Accounts Payable by G/L Distribution Report

Invoice Date Range 12/01/18 - 11/30/19

Vendor	Invoice No.	Invoice Description	Status	Held Reason	Invoice Date	Due Date	G/L Date	Received Date	Payment Date	Invoice Amount
Fund **108 - Hope Creek**										
Department **21 - Hope Creek**										
Sub Department **41 - Patient Care**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	27202943	ARC;CPR Training/Friendship Manor;1/11/19;4527-9726	Paid by Check # 67696		01/17/2019	01/17/2019	01/17/2019		02/22/2019	220.00
104890 - FIRST MIDWEST BANK	27354120	ARC CPR;CPR training/Friendship Manor;1/19/19;4527-9726	Paid by Check # 67935		02/19/2019	02/19/2019	02/19/2019		03/22/2019	198.00
104890 - FIRST MIDWEST BANK	27708387	ARC CPR;CPR Training/friendship Manor;2/8/19;4527-9726	Paid by Check # 67935		02/19/2019	02/19/2019	02/19/2019		03/22/2019	110.00
104890 - FIRST MIDWEST BANK	27945970	ARC;CPR Training Class/Friendship Manor;2/22/19;4527-9726	Paid by Check # 68381		03/20/2019	03/20/2019	03/20/2019		04/18/2019	132.00
104890 - FIRST MIDWEST BANK	28074412	ARC;CPR Training class;3/1/19;4527-9726	Paid by Check # 68381		03/20/2019	03/20/2019	03/20/2019		04/18/2019	198.00
104890 - FIRST MIDWEST BANK	28549931	ARC;CPR Training/Friendship Manor;3/27/19;4527-9726	Paid by Check # 68698		04/18/2019	04/18/2019	04/18/2019		05/24/2019	176.00
104890 - FIRST MIDWEST BANK	28592768	ARC;CPR Trainig;3/29/19;4527-9726	Paid by Check # 68698		04/18/2019	04/18/2019	04/18/2019		05/24/2019	110.00
104890 - FIRST MIDWEST BANK	28993964	American Red Cross;CPR Training;4/19/19;4527-9726	Paid by Check # 68940		05/21/2019	05/21/2019	05/21/2019		06/21/2019	132.00
104890 - FIRST MIDWEST BANK	29430061	American red Cross;CPR Train/Freindship Manor;5/10/19;4527-9726	Paid by Check # 68940		05/21/2019	05/21/2019	05/21/2019		06/21/2019	132.00
104890 - FIRST MIDWEST BANK	29495729	American red Cross;Inst. Renewal;5/14/19;4527-9726	Paid by Check # 69155		06/19/2019	06/19/2019	06/19/2019		07/19/2019	92.00



Rock Island County

Accounts Payable by G/L Distribution Report

Invoice Date Range 12/01/18 - 11/30/19

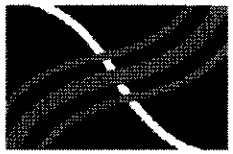
Vendor	Invoice No.	Invoice Description	Status	Held Reason	Invoice Date	Due Date	G/L Date	Received Date	Payment Date	Invoice Amount
Fund **108 - Hope Creek**										
Department **21 - Hope Creek**										
Sub Department **41 - Patient Care**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	29866795	American red Cross;CPR Training;5/30/19;4527-9726	Paid by Check # 69155		06/19/2019	06/19/2019	06/19/2019		07/19/2019	44.00
104890 - FIRST MIDWEST BANK	29867326	ARC;Cpr Training/Friendship Manor;5/30/19;4527-9726	Paid by Check # 69155		06/19/2019	06/19/2019	06/19/2019		07/19/2019	176.00
104890 - FIRST MIDWEST BANK	971386999	EB IL Summit ON;Tring on Antibotic Stuartship;6/21/19;4529-1127	Paid by Check # 69415		07/19/2019	07/19/2019	07/19/2019		08/23/2019	40.50
104890 - FIRST MIDWEST BANK	247002	HDG;ICD-10 Summer School reg;7/11/19;4529-1127	Paid by Check # 69415		07/19/2019	07/19/2019	07/19/2019		08/23/2019	150.00
104890 - FIRST MIDWEST BANK	30323258	ARC;CPR Training;6/19/19;4529-9726	Paid by Check # 69415		07/22/2019	07/22/2019	07/22/2019		08/23/2019	88.00
104890 - FIRST MIDWEST BANK	30519195	ARC;CPR Training;6/28/19;4529-9726	Paid by Check # 69415		07/22/2019	07/22/2019	07/22/2019		08/23/2019	132.00
104890 - FIRST MIDWEST BANK	31246903	American Red Cross;CPR Class/Friendship Manor;8/8/19;4527-9726	Paid by Check # 69654		08/19/2019	08/19/2019	08/19/2019		09/20/2019	198.00
104890 - FIRST MIDWEST BANK	392722	Healthdimen/Webinar;8/14/19;4529-1127	Paid by Check # 69873		09/23/2019	09/23/2019	09/23/2019		10/18/2019	35.00
104890 - FIRST MIDWEST BANK	31483915	ARC;CPR Training/Friendship Manor;8/21/19;4527-9726	Paid by Check # 69873		09/23/2019	09/23/2019	09/23/2019		10/18/2019	154.00
104890 - FIRST MIDWEST BANK	31608904	ARC;CPR Traoning/Friendship Manor;8/28/19;4527-9726	Paid by Check # 69873		09/23/2019	09/23/2019	09/23/2019		10/18/2019	154.00
104890 - FIRST MIDWEST BANK	31648313	ARC;CPR Training;8/30/19;4527-9726	Paid by Check # 69873		09/23/2019	09/23/2019	09/23/2019		10/18/2019	132.00
104890 - FIRST MIDWEST BANK	32071141	ARC;CPR Training;9/27/19;4527-9726	Paid by Check # 70121		10/24/2019	10/24/2019	10/24/2019		11/22/2019	88.00

Rock Island County

Accounts Payable by G/L Distribution Report

Invoice Date Range 12/01/18 - 11/30/19

Vendor	Invoice No.	Invoice Description	Status	Held Reason	Invoice Date	Due Date	G/L Date	Received Date	Payment Date	Invoice Amount
Fund **108 - Hope Creek**										
Department **21 - Hope Creek**										
Sub Department **41 - Patient Care**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	32637832	ARC;CPR Training class/Friendship Manor;11/7/19;4527-9726	Paid by Check # 70352		11/19/2019	11/19/2019	11/19/2019		12/20/2019	154.00
				Object detail **630.00 - Training & Education** Totals			Invoice Transactions 27			$3,683.50
				Sub Department **41 - Patient Care** Totals			Invoice Transactions 27			$3,683.50
Sub Department **42 - Culinary**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	ce3h0-hkc978f	State Food Safety;Cert. of Completion;11/14/18;4523-7856	Paid by Check # 67964		12/19/2018	12/19/2018	11/30/2018		04/09/2019	10.00
104890 - FIRST MIDWEST BANK	ce3ga-hkc96bd	state Food Safety;Cert. of Completion;11/14/18;4523-7856	Paid by Check # 67964		12/19/2018	12/19/2018	11/30/2018		04/09/2019	10.00
104890 - FIRST MIDWEST BANK	ce9jh-hkd6if5	State Food Safety;Cert of Completion;11/16/18;4523-7856	Paid by Check # 67964		12/19/2018	12/19/2018	11/30/2018		04/09/2019	10.00
104890 - FIRST MIDWEST BANK	cek91-hkf4739	State Food Safety;Cert of Completion;11/20/18;4523-7856	Paid by Check # 67964		12/19/2018	12/19/2018	11/30/2018		04/09/2019	10.00
104890 - FIRST MIDWEST BANK	cfjac-hkjbh9c	State Food Safety;Cert. of Completion;11/30/18;4523-7856	Paid by Check # 67964		12/19/2018	12/19/2018	11/30/2018		04/09/2019	10.00
104890 - FIRST MIDWEST BANK	631670	BHC;Food Service sanitation Manager class;12/3/18;4523-7856	Paid by Check # 67964		12/21/2018	12/21/2018	12/21/2018		04/09/2019	147.00
104890 - FIRST MIDWEST BANK	3279849	State Food Safety;Cert of Completion;12/5/18;4523-7856	Paid by Check # 67964		12/21/2018	12/21/2018	12/21/2018		04/09/2019	10.00
104890 - FIRST MIDWEST BANK	3281399	State Fodd Safety;Certif. of Completion;12/5/18;4523-7856	Paid by Check # 67964		12/21/2018	12/21/2018	12/21/2018		04/09/2019	10.00



Rock Island County

Accounts Payable by G/L Distribution Report

Invoice Date Range 12/01/18 - 11/30/19

Vendor	Invoice No.	Invoice Description	Status	Held Reason	Invoice Date	Due Date	G/L Date	Received Date	Payment Date	Invoice Amount
Fund **108 - Hope Creek**										
Department **21 - Hope Creek**										
Sub Department **42 - Culinary**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	662861	ANFP;CDM Credentialing Exam;12/6/18;4523-7856	Paid by Check # 67964		12/21/2018	12/21/2018	12/21/2018		04/09/2019	399.00
104890 - FIRST MIDWEST BANK	d102a-i0k7c56	State Food Safety;Cert of Compl;1/18/19;4528-7174	Paid by Check # 67935		02/15/2019	02/15/2019	02/15/2019		03/22/2019	10.00
104890 - FIRST MIDWEST BANK	d2j4h-i14eb25	State Food Safety;cert of compl;1/30/19;4528-7174	Paid by Check # 67935		02/15/2019	02/15/2019	02/15/2019		03/22/2019	10.00
104890 - FIRST MIDWEST BANK	d363h-i15c9ee	State Food Safety;cert of compl;2/1/19;4528-7174	Paid by Check # 67935		02/15/2019	02/15/2019	02/15/2019		03/22/2019	10.00
104890 - FIRST MIDWEST BANK	d43k0-i185557	State Food Safety;Cert of Compl;2/7/19;4528-7174	Paid by Check # 67935		02/15/2019	02/15/2019	02/15/2019		03/22/2019	10.00
104890 - FIRST MIDWEST BANK	d4b76-i192608	State Food safety;Cert of Compl;2/9/19;4528-7174	Paid by Check # 67935		02/15/2019	02/15/2019	02/15/2019		03/22/2019	10.00
104890 - FIRST MIDWEST BANK	694122	BHC;Food Protection Mang Class;2/13/19;4528-7174	Paid by Check # 68381		03/19/2019	03/19/2019	03/19/2019		04/18/2019	147.00
104890 - FIRST MIDWEST BANK	e08bb-i3d61ag	State Food safety;Cert of Completion;5/24/19;4529-1127	Paid by Check # 69155		06/19/2019	06/19/2019	06/19/2019		07/19/2019	10.00
104890 - FIRST MIDWEST BANK	e1b28-i3g8e5i	State Food saefty;Cert of Complet;5/31/19;4529-1127	Paid by Check # 69155		06/19/2019	06/19/2019	06/19/2019		07/19/2019	10.00
104890 - FIRST MIDWEST BANK	e1g04-i3gi695	State Food Safety;Certification of Completion;6/1/19;4529-1127	Paid by Check # 69155		06/19/2019	06/19/2019	06/19/2019		07/19/2019	10.00
104890 - FIRST MIDWEST BANK	e8a8i-i4d3i5c	State Food Safety;Cert of Completion;7/10/19;4529-1127	Paid by Check # 69415		07/19/2019	07/19/2019	07/19/2019		08/23/2019	10.00
104890 - FIRST MIDWEST BANK	eddcg-i551gce	State Food Safety;Cert of Compl;8/8/19;4529-1127	Paid by Check # 69654		08/16/2019	08/16/2019	08/16/2019		09/20/2019	10.00

Accounts Payable by G/L Distribution Report

Invoice Date Range 12/01/18 - 11/30/19

Vendor	Invoice No.	Invoice Description	Status	Held Reason	Invoice Date	Due Date	G/L Date	Received Date	Payment Date	Invoice Amount
Fund **108 - Hope Creek**										
Department **21 - Hope Creek**										
Sub Department **42 - Culinary**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	edd69-i5516ia	State Food Safety;Cert of Compl;8/8/19;4529-1127	Paid by Check # 69654		08/16/2019	08/16/2019	08/16/2019		09/20/2019	10.00
104890 - FIRST MIDWEST BANK	eff5f-i5a81ce	State Food Safety, Cert of Compl;8/20/19;4529-1127	Paid by Check # 69873		09/23/2019	09/23/2019	09/23/2019		10/18/2019	10.00
104890 - FIRST MIDWEST BANK	ehd3g-i5ehab8	State Food Safety;Cert of Completion;8/30/19;4529-1127	Paid by Check # 69873		09/23/2019	09/23/2019	09/23/2019		10/18/2019	10.00
104890 - FIRST MIDWEST BANK	ej9cb-i5jf4k2	State Food Safety;Cert of Completion;9/10/19;4529-1127	Paid by Check # 69873		09/23/2019	09/23/2019	09/23/2019		10/18/2019	10.00
104890 - FIRST MIDWEST BANK	ekfeh-i61i0i3	State Food Safety;Cert of Compl;9/17/19;4527-1127	Paid by Check # 70121		10/23/2019	10/23/2019	10/23/2019		11/22/2019	10.00
104890 - FIRST MIDWEST BANK	3800416	State Food Safety;Cert of Complet;9/27/19;4527-1127	Paid by Check # 70121		10/23/2019	10/23/2019	10/23/2019		11/22/2019	10.00
104890 - FIRST MIDWEST BANK	f2d8c-i68jbhc	State Food Safety;Certificate of Complet;10/3/19;4527-1127	Paid by Check # 70121		10/23/2019	10/23/2019	10/23/2019		11/22/2019	10.00
104890 - FIRST MIDWEST BANK	3821980	State Food Safety;Certificate of Complet;10/9/19;4527-1127	Paid by Check # 70121		10/23/2019	10/23/2019	10/23/2019		11/22/2019	10.00
104890 - FIRST MIDWEST BANK	f5jie-i6h7ee7	State Food Safety;Cert of Complet;10/22/19;4529-1127	Paid by Check # 70352		11/19/2019	11/19/2019	11/19/2019		12/20/2019	10.00
104890 - FIRST MIDWEST BANK	f6g4k-i6j4153	State Food Safety;Cert of Compl;10/26/19;4529-1127	Paid by Check # 70352		11/19/2019	11/19/2019	11/19/2019		12/20/2019	10.00
104890 - FIRST MIDWEST BANK	f8k30-i7487g3	State Food Safety;Cert of Compl;11/9/19;4529-1127	Paid by Check # 70352		11/19/2019	11/19/2019	11/19/2019		12/20/2019	10.00

Rock Island County

Accounts Payable by G/L Distribution Report

Invoice Date Range 12/01/18 - 11/30/19

Vendor	Invoice No.	Invoice Description	Status	Held Reason	Invoice Date	Due Date	G/L Date	Received Date	Payment Date	Invoice Amount
Fund **108 - Hope Creek**										
Department **21 - Hope Creek**										
Sub Department **42 - Culinary**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	f8k01-i74821g	State Food Safety;Cert of Compl;11/9/19;4529-1172	Paid by Check # 70352		11/19/2019	11/19/2019	11/19/2019		12/20/2019	10.00
Object detail **630.00 - Training & Education** Totals							Invoice Transactions 32			$983.00
Sub Department **42 - Culinary** Totals							Invoice Transactions 32			$983.00
Sub Department **44 - Occupational Therapy**										
Object detail **630.00 - Training & Education**										
107795 - REHAB SPECIALISTS LLC DBA CONSONUS REHAB	20736	Consonus 11/1/2015-11/30/2018	Paid by Check # 68709		12/06/2018	12/06/2018	11/30/2018		05/31/2019	261.00
104076 - WORKING CASH-HOPE CREEK CARE CENTER	CK# 1565	Working Cash;Reim Patty Atwell for RA Class;1/22/19	Paid by Check # 68936		01/29/2019	01/29/2019	01/29/2019		06/21/2019	249.00
107795 - REHAB SPECIALISTS LLC DBA CONSONUS REHAB	21647	Consonus 9/2019	Paid by Check # 70112		10/04/2019	10/04/2019	10/04/2019		11/22/2019	226.50
Object detail **630.00 - Training & Education** Totals							Invoice Transactions 3			$736.50
Sub Department **44 - Occupational Therapy** Totals							Invoice Transactions 3			$736.50
Sub Department **89 - Social Services**										
Object detail **630.00 - Training & Education**										
104890 - FIRST MIDWEST BANK	C8529	Proforte, Inc;Training;1/10/19;4528-6416	Paid by Check # 67696		01/17/2019	01/17/2019	01/17/2019		02/22/2019	199.00
Object detail **630.00 - Training & Education** Totals							Invoice Transactions 1			$199.00
Sub Department **89 - Social Services** Totals							Invoice Transactions 1			$199.00
Department **21 - Hope Creek** Totals							Invoice Transactions 68			$7,682.00
Fund **108 - Hope Creek** Totals							Invoice Transactions 68			$7,682.00
Grand Totals							Invoice Transactions 68			$7,682.00

* = Prior Fiscal Year Activity

Adj to tie to WTB $1,170

Trial Balance $6,512