

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0048694</u>			II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Hope Creek Care Center</u>			I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/2019</u> to <u>9/30/2020</u> 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.																																															
Address: <u>4343 Kennedy Drive</u> <u>East Moline</u> <u>61244</u>																																																		
Number City Zip Code																																																		
County: <u>Rock Island</u>																																																		
Telephone Number: <u>(309) 796-6600</u> Fax # <u>(309) 796-6001</u>																																																		
HFS ID Number: _____			<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u></td></tr><tr><td>(Telephone) <u>(847) 517-7070</u> Fax # (847)<u>517-7067</u></td></tr></table>			Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>RSM US LLP</u> <u>20 N. Martingale Road, Ste. 500 Schaumburg, IL 60173</u>	(Telephone) <u>(847) 517-7070</u> Fax # (847) <u>517-7067</u>																																			
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	(Telephone) <u>(847) 517-7070</u> Fax # (847) <u>517-7067</u>																																																	
Date of Initial License for Current Owners: <u>9/1/1972</u>																																																		
Type of Ownership:																																																		
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☒</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☒</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other</td><td></td><td>_____</td></tr></table>			☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☒	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☒	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.		_____			☐	Limited Liability Co.		_____			☐	Trust					☐	Other		_____
☐	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☒	GOVERNMENTAL																																													
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		☐	Trust																																															
		☐	Other		_____																																													
In the event there are further questions about this report, please contact:			MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001																																															
Name: <u>Amanda Springborn</u> Telephone Number: <u>(314) 925-3838</u> Email Address: _____																																																		

Facility Name & ID Number Hope Creek Care Center# 0048694 Report Period Beginning: 12/1/2019 Ending: 9/30/2020

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>245</u>	Skilled (SNF)	<u>245</u>	<u>74,725</u>	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	<u>245</u>	TOTALS	<u>245</u>	<u>74,725</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>27,776</u>	<u>7,657</u>	<u>6,081</u>	<u>41,514</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>27,776</u>	<u>7,657</u>	<u>6,081</u>	<u>41,514</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 55.56%

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?

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

YES

☒

NO

☐Note : Non-allowable costs have been
eliminated in Schedule V, Column 7.

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

YES

☐

NO

☒

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

Date started

9/1/1972

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

YES

☐

Date

NO

☒

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

YES

☒

NO

☐If YES, enter number
of beds certified245

and days of care provided

1,601

Medicare Intermediary

Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

☐

MODIFIED

CASH*

☒

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year:

9/30/2020

Fiscal Year:

9/30/2020

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

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2019 Ending: 9/30/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	541,199	41,548	20,108	602,855		602,855		602,855			1
2	Food Purchase		330,440		330,440		330,440	(4,337)	326,103			2
3	Housekeeping	255,343	33,451	1,985	290,779		290,779		290,779			3
4	Laundry	192,004	18,277	-	210,281		210,281		210,281			4
5	Heat and Other Utilities			226,873	226,873		226,873		226,873			5
6	Maintenance	163,877	48,311	101,770	313,958		313,958		313,958			6
7	Other (specify):*	-	-	-								7
8	TOTAL General Services	1,152,423	472,027	350,736	1,975,186		1,975,186	(4,337)	1,970,849			8
	B. Health Care and Programs											
9	Medical Director	-	-	-				30,000	30,000			9
10	Nursing and Medical Records	3,621,766	368,786	2,333,919	6,324,471		6,324,471	(30,915)	6,293,556			10
10a	Therapy	192,824	-	-	192,824		192,824		192,824			10a
11	Activities	322,797	4,217	642	327,656		327,656		327,656			11
12	Social Services	106,873	-	-	106,873		106,873	(44,208)	62,665			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	TOTAL Health Care and Programs	4,244,260	373,003	2,334,561	6,951,824		6,951,824	(45,123)	6,906,701			16
	C. General Administration											
17	Administrative	-	-	-				104,375	104,375			17
18	Directors Fees			-				12,326	12,326			18
19	Professional Services			-				320,190	320,190			19
20	Dues, Fees, Subscriptions & Promotions			7,394	7,394		7,394		7,394			20
21	Clerical & General Office Expenses	339,987	5,704	403,510	749,201		749,201	(104,760)	644,441			21
22	Employee Benefits & Payroll Taxes			1,223,356	1,223,356		1,223,356	1,462,827	2,686,183			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			1,471	1,471		1,471		1,471			24
25	Other Admin. Staff Transportation		-	1,633	1,633		1,633		1,633			25
26	Insurance-Prop.Liab.Malpractice			18,605	18,605		18,605		18,605			26
27	Other (specify):*			-								27
28	TOTAL General Administration	339,987	5,704	1,655,969	2,001,660		2,001,660	1,794,958	3,796,618			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,736,670	850,734	4,341,266	10,928,670		10,928,670	1,745,498	12,674,168			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			-				521,654	521,654			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			329,856	329,856		329,856	(5,158)	324,698			32
33	Real Estate Taxes			-								33
34	Rent-Facility & Grounds			-				187	187			34
35	Rent-Equipment & Vehicles			16,622	16,622		16,622		16,622			35
36	Other (specify):*			-								36
37	TOTAL Ownership			346,478	346,478		346,478	516,683	863,161			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	173,199	254,346	427,545		427,545		427,545			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			-				354,359	354,359			42
43	Other (specify):* Non-Allowable Cos	-	233	4,770,368	4,770,601		4,770,601	(4,770,601)				43
44	TOTAL Special Cost Centers		173,432	5,024,714	5,198,146		5,198,146	(4,416,242)	781,904			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,736,670	1,024,166	9,712,458	16,473,294		16,473,294	(2,154,061)	14,319,233			45

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

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	(4,337)	2		4
5	Telephone, TV & Radio in Resident Rooms	(24,093)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(915)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	521,654	30		9
10	Interest and Other Investment Income	(5,158)	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	(4,436,742)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,949,591)		\$	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)	1,795,530		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,795,530		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (2,154,061)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs - Part A	\$ (15,075)	43	1
2	Principal	(4,730,000)	43	2
3	Professional Services	(1,200)	43	3
4	Reclass Provider Bed Tax	354,359	42	4
5	Misc Income	(385)	21	5
6	Food Purchases	(233)	43	6
7	Admissions Coordinator Salary	(44,208)	12	7
8				8
9				9
10				10
11				11
12				12
13				13
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,436,742)		49

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.

☒ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Welfare Committee	\$	Rock Island County	100	\$ 12,326	\$ 12,326	1
2	V	19	Risk Management		Rock Island County	100	201,001	201,001	2
3	V	19	General Management		Rock Island County	100	11,653	11,653	3
4	V	19	Auditor		Rock Island County	100	19,681	19,681	4
5	V	19	Information Systems		Rock Island County	100	38,833	38,833	5
6	V	19	Treasurer		Rock Island County	100	259	259	6
7	V	19	County Board		Rock Island County	100	48,763	48,763	7
8	V	22	Worker's Comp		Rock Island County	100	51,027	51,027	8
9	V	22	FICA		Rock Island County	100	533,855	533,855	9
10	V	22	IMRF		Rock Island County	100	877,945	877,945	10
11	V	34	County Buildings		Rock Island County	100	187	187	11
12	V								12
13	V								13
14	Total			\$			\$ 1,795,530	\$ * 1,795,530	14

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

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
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29								29
30								30

Facility Name & ID Number Hope Creek Care Center # 0048694 Report Period Beginning: 12/1/2019 Ending: 9/30/2020

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jessey Hullon	CHAIR, NUR HM COMM	DIRECTOR	0%	0	1	2.00	Salary	\$ 3,582	18(7)	1
2	Michael Kelly	NURS HM COMM	DIRECTOR	0%	0	1	2.00	Salary	1,457	18(7)	2
3	Ginny Shelton	NURS HM COMM	DIRECTOR	0%	0	1	2.00	Salary	1,457	18(7)	3
4	Rod Simmer	NURS HM COMM	DIRECTOR	0%	0	1	2.00	Salary	1,457	18(7)	4
5	Carol Near	NURS HM COMM	DIRECTOR	0%	0	1	2.00	Salary	1,457	18(7)	5
6	Tim Erno	NURS HM COMM	DIRECTOR	0%	0	1	2.00	Salary	1,457	18(7)	6
7	Bryon Tyson	NURS HM COMM	DIRECTOR	0%	0	1	2.00	Salary	1,457	18(7)	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,326		13

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

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

Facility Name & ID Number Hope Creek Care Center# 0048694 Report Period Beginning: 12/1/2019 Ending: 12/30/2020

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 ☒ 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		201,001		1	201,001	2
3	19	General Management	Cost Allocation Study	1		11,653		1	11,653	3
4	19	Auditor	Cost Allocation Study	1		19,681		1	19,681	4
5	19	Information Systems	Cost Allocation Study	1		38,833		1	38,833	5
6	19	Treasurer	Cost Allocation Study	1		259		1	259	6
7	19	County Board	Cost Allocation Study	1		48,763		1	48,763	7
8	22	Worker's Comp	Cost Allocation Study	1		51,027		1	51,027	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		187		1	187	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					\$ 1,795,530	\$ 12,326		\$ 1,795,530	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	Bond (2013 Series)		X	Capital Expenditures	Semi-Annual	5/9/2013	\$ 3,700,000	\$ 3,330,000	12/1/2024	0.02	\$ 62,038	1
2	Bond (2016 Series)		X	Capital Expenditures	Semi-Annual	9/27/2016	9,105,000	7,705,000	46722	0.02	267,818	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 12,805,000	\$ 11,035,000			\$ 329,856	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(5,158)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (5,158)	14
15	TOTALS (line 9+line14)						\$ 12,805,000	\$ 11,035,000			\$ 324,698	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.)

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

B. Real Estate Taxes

[illegible]

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.

2019 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 Jim Snider

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 2019 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 2019.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>County facility exempt from RE tax</u>		\$	\$
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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 120,731

B. General Construction Type: Exterior Brick Frame Block & Brick Number of Stories Two

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

E. Does this cost report reflect any organization or pre-operating costs which are being amortized?
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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Non-Facility	280	1917	\$ 18,526	1
2	Facility		2006	1,598,000	2
3	TOTALS	280		\$ 1,616,526	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	245		2009	2009	\$ 19,711,553	\$ -	40	\$ 492,764	\$ 492,764	\$ 5,666,798	4
5						-		-			5
6						-		-			6
7						-		-			7
8						-		-			8
	Improvement Type**										
9	Front Lawn Landscaping		2009		4,983	-	10			4,983	9
10	Parking Lots		2009		215,420	-	30	7,181	7,181	82,581	10
11						-		-			11
12	Time Clock		2010		13,500	-	15	900	900	9,450	12
13						-		-			13
14	Trane Furnace & AC in HCC Annex Bldg		2014		6,724	-	10	672	672	4,370	14
15						-		-			15
16	Picnic Pavilion		2015		157,830	-	20	7,892	7,892	43,403	16
17	2 Thermostats - Rooftop Unit 12 on Building 5		2015		2,645	-	10	265	265	1,455	17
18						-		-			18
19	Carpet - Dining Room		2016		17,557	-	10	1,756	1,756	8,780	19
20						-		-			20
21	Paint Exterior Red Siding Panels - Outside of Building		2019		19,875	-	10	1,988	1,988	2,982	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

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	\$		\$ 513,417	\$ 513,417	\$ 5,824,802	70

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

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	\$ 5,276	\$	\$ 1,055	\$ 1,055	5-7	\$ 2,110	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	743,115					743,115	73
74								74
75	TOTALS	\$ 748,391	\$	\$ 1,055	\$ 1,055		\$ 745,225	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	93,045	79
80	TOTALS			\$ 190,590	\$	\$ 7,182	\$ 7,182		\$ 177,425	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 521,654	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 521,654	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,747,452	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: 9/30/2020

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	22,743
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
						-		
TOTAL			106,210	-	7,182	-		93,045

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			187			6
7	TOTAL				\$ 187			7

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 16,622 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.

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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

Facility Name: Hope Creek Care Center
IDPH License ID Number: 0048694
Fiscal Year End: 9/30/2020

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
Oxygen, Mattress & Concentrator	16,444
Maintenance Equipment	178
Total - Line 16	16,622

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

(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.

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L39, C3	hrs	\$	1,411	\$ 101,876	\$	1,411	\$ 101,876	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		940	61,709		940	61,709	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		1,663	90,761		1,663	90,761	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				167,074		167,074	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					6,125		6,125	12
13	Other (specify):									13
14	TOTAL			\$	4,014	\$ 254,346	\$ 173,199	4,014	\$ 427,545	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 9,611	\$ 9,611	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	368,355	368,355	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	295,000	295,000	5
6	Prepaid Insurance	-	-	6
7	Other Prepaid Expenses	-	-	7
8	Accounts Receivable (owners or related parties)	249,946	249,946	8
9	Other(specify): See Sch 17A	32,861	32,861	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 955,773	\$ 955,773	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)	-	(6,747,452)	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)	\$	\$ 15,958,142	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 955,773	\$ 16,913,915	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,201,881	\$ 1,201,881	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	-	-	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	39,600	39,600	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	6,415,062	6,415,062	36
37	See Sch 17A	4,460	4,460	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 7,661,003	\$ 7,661,003	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	-	-	39
40	Mortgage Payable	-	-	40
41	Bonds Payable	-	11,035,000	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)	\$	\$ 11,035,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,661,003	\$ 18,696,003	46
47	TOTAL EQUITY (page 18, line 24)	\$ (6,705,230)	\$ (1,782,088)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 955,773	\$ 16,913,915	48

*(See instructions.)

Facility Name: Hope Creek Care Center
IDPH License ID Number: 0048694
Fiscal Year End: 9/30/2020

Schedule 17A

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

Description	After	
	Operating	Consolidation
Checks/Stop payments	32,564	32,564
Int. Rec. on Investments	297	297
Total - Line 9	32,861	32,861

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

Description	After	
	Operating	Consolidation
Due other Funds	4,051,402	4,051,402
Rev/Tax anticipation loan payable	2,300,000	2,300,000
Deferred Revenue	63,660	63,660
Total - Line 36	6,415,062	6,415,062

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

Description	After	
	Operating	Consolidation
Deposits	400	400
Unclaimed Voucher Checks	2,911	2,911
Unclaimed Payroll Checks	1,149	1,149
Total - Line 36	4,460	4,460

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,358,278)	1
2	Restatements (describe):		2
3	Prior period adjustment	(237,113)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,595,391)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,109,839)	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)	\$ (1,109,839)	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)	\$ (6,705,230)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hope Creek Care Center

0048694

Report Period Beginning: 12/1/2019

Ending:

9/30/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,407,861	1
2	Discounts and Allowances for all Levels	(-)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,407,861	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	24,271	6
7	Oxygen	-	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 24,271	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	863,480	10
11	CNA Training Reimbursements	-	11
12	Gift and Coffee Shop	-	12
13	Barber and Beauty Care	-	13
14	Non-Patient Meals	4,337	14
15	Telephone, Television and Radio	5,506	15
16	Rental of Facility Space	-	16
17	Sale of Drugs	-	17
18	Sale of Supplies to Non-Patients	915	18
19	Laboratory	-	19
20	Radiology and X-Ray	-	20
21	Other Medical Services	-	21
22	Laundry	450	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 874,688	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	5,158	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5,158	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		-	28
28a	<u>See Sch 19A</u>	6,051,477	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,051,477	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,363,455	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,975,186	31
32	Health Care	6,951,824	32
33	General Administration	2,001,660	33
	B. Capital Expense		
34	Ownership	346,478	34
	C. Ancillary Expense		
35	Special Cost Centers	5,198,146	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)*	\$ 16,473,294	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,109,839)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,109,839)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,296,572	44
45	Private Pay - Net Inpatient Revenue	58,184	45
46	Medicare - Net Inpatient Revenue	565,118	46
47	Other-(specify) <u>Patient Fees</u>	1,616,493	47
48	Other-(specify) <u>Veterans</u>	871,494	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,407,861	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: 9/30/2020

Schedule 19A

XVII. Income Statement

Line 28 Other Revenue (specify):

Description	Amount
Inter governmental transfer funds	462,030
Transportation charge	220
CPR Training fees	600
Miscellaneous-other revenue	1,186
Transfer from nurse home taxlevy	2,671,987
Sales of Capital Assets	4,000,000
Transfer to General Fund	(694,134)
Transfer to Other Agencies	(390,412)
Total - Line 28	6,051,477

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	8	986	\$ 53,369	\$ 54.13	1
2	Assistant Director of Nursing	983	1,112	40,191	36.14	2
3	Registered Nurses	9,020	11,929	340,828	28.57	3
4	Licensed Practical Nurses	31,108	39,949	909,526	22.77	4
5	CNAs & Orderlies	101,125	124,574	2,188,047	17.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,654	9,071	192,824	21.26	8
9	Activity Director					9
10	Activity Assistants	17,392	19,897	322,797	16.22	10
11	Social Service Workers	2,373	2,814	62,665	22.27	11
12	Dietician					12
13	Food Service Supervisor	3,067	3,866	81,097	20.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	28,132	32,587	460,102	14.12	15
16	Dishwashers					16
17	Maintenance Workers	6,405	7,968	163,877	20.57	17
18	Housekeepers	13,586	17,713	255,343	14.42	18
19	Laundry	9,698	12,455	192,004	15.42	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,814	15,061	339,987	22.57	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 Care See Sch 20A	3,975	4,399	89,805	20.41	32
33	Other(specify) Admissions	1,522	2,239	44,208	19.74	33
34	TOTAL (lines 1 - 33)	248,862	306,620	\$ 5,736,670 *	\$ 18.71	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 20,108	1(3)	35
36	Medical Director	Monthly	30,000	9(7)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,194	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	642	11(3)	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 62,944		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	7,395	\$ 388,069	10(3)	50
51	Licensed Practical Nurses	20,185	826,942	10(3)	51
52	Certified Nurse Assistants/Aides	38,167	1,076,714	10(3)	52
53	TOTAL (lines 50 - 52)	65,747	\$ 2,291,725		53

Facility Name: Hope Creek Care Center
IDPH License ID Number: 0048694
Fiscal Year End: 9/30/2020

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	1,346	1,423	29,415	\$ 20.67
Central Supply Clerk	1,329	1,548	29,313	\$ 18.94
Memory Care Coordinator	1,300	1,428	31,077	\$ 21.76
Total - Line 32 Other Health Care (specify):	3,975	4,399	89,805	

Facility Name: Hope Creek Care Center
IDPH License ID Number: 0048694
Fiscal Year End: 9/30/2020

Schedule 21A

XIX. SUPPORT SCHEDULES
B. Administrative Other

Name	Function	Amount
Trudi Whittington	Int. Administrator	104,375
Total (agree to Schedule V, line 17, column 7)		104,375

Facility Name: Hope Creek Care Center
IDPH License ID Number: 0048694
Fiscal Year End: 9/30/2020

Schedule 21C

XIX. SUPPORT SCHEDULES
C. Professional Services

Vendor	Type	Amount
Total (agree to Schedule V, line 19, column 3)		-
Allocated from County Auditor		19,681
Allocated from County County Board		48,763
Allocated from County General Management		11,653
Allocated from County Information System		38,833
Allocated from County Risk Management		201,001
Allocated from County Treasurer		259
Total (agree to Schedule V, line 19, column 8)		320,190

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? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,394 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. \$ 354,359
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. \$ - Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,337
- (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 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.