

		FOR BHF USE					

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**2016**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2016)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0051334</u></p> <p><b>Facility Name:</b> <u>Integrity HC of Alton</u></p> <p><b>Address:</b> <u>3552 Wickenhauser</u> <u>Alton</u> <u>62002</u>  Number City Zip Code</p> <p><b>County:</b> <u>Madison</u></p> <p><b>Telephone Number:</b> <u>708-236-0000</u> <b>Fax #</b> <u>708-236-0001</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>03/01/11</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____ </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Daniel S. Gaafar</u> <b>Telephone Number:</b> <u>317-237-5500</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Alan Irni</u> (Title) <u>CFO</u></td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u> (Firm Name &amp; Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225</u> (Telephone) <u>317-237-5500</u> <b>Fax #</b> <u>317-237-5503</u></td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Alan Irni</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u> (Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225</u> (Telephone) <u>317-237-5500</u> <b>Fax #</b> <u>317-237-5503</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Alan Irni</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u> (Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225</u> (Telephone) <u>317-237-5500</u> <b>Fax #</b> <u>317-237-5503</u>							

Facility Name & ID Number Integrity HC of Alton

# 0051334 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

**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	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	132	Skilled (SNF)	132	48,312	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,934	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	181	TOTALS	181	66,246	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,017	2,467	3,448	25,932	8
9	SNF/PED					9
10	ICF	7,404	913	18	8,335	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,421	3,380	3,466	34,267	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.73%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

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  NO

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 03/01/11

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

YES  Date 03/01/11 NO

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

YES  NO  If YES, enter number of beds certified 37 and days of care provided 3,399

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: 12/31/16 Fiscal Year: 12/31/16

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

Facility Name & ID Number Integrity HC of Alton # 0051334 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

**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
	<b>A. General Services</b>										
1	Dietary	194,198	19,807	8,684	222,689		222,689	(99)	222,590		1
2	Food Purchase		202,067		202,067		202,067		202,067		2
3	Housekeeping	125,364	20,189		145,553		145,553		145,553		3
4	Laundry	70,814	13,043		83,857		83,857		83,857		4
5	Heat and Other Utilities			162,208	162,208		162,208	3,600	165,808		5
6	Maintenance	55,305	21,333	30,965	107,603		107,603	660	108,263		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	445,681	276,439	201,857	923,977		923,977	4,161	928,138		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	1,988,886	135,895	46,169	2,170,950		2,170,950		2,170,950		10
10a	Therapy			623,090	623,090		623,090		623,090		10a
11	Activities	73,348	8,713		82,061		82,061		82,061		11
12	Social Services	52,266		4,234	56,500		56,500		56,500		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Pharmacy Consult</b>			8,630	8,630		8,630		8,630		15
16	<b>TOTAL Health Care and Programs</b>	2,114,500	144,608	712,123	2,971,231		2,971,231		2,971,231		16
	<b>C. General Administration</b>										
17	Administrative	88,596			88,596		88,596		88,596		17
18	Directors Fees										18
19	Professional Services			324,923	324,923		324,923	(296,372)	28,551		19
20	Dues, Fees, Subscriptions & Promotions			7,373	7,373		7,373	73	7,446		20
21	Clerical & General Office Expenses	107,761	34,398	65,914	208,073		208,073	207,199	415,272		21
22	Employee Benefits & Payroll Taxes			486,270	486,270		486,270	20,367	506,637		22
23	Inservice Training & Education										23
24	Travel and Seminar			11,966	11,966		11,966	6,378	18,344		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			200,664	200,664		200,664	386	201,050		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	196,357	34,398	1,097,110	1,327,865		1,327,865	(61,969)	1,265,896		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,756,538	455,445	2,011,090	5,223,073		5,223,073	(57,808)	5,165,265		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 &amp; ID Number

Integrity HC of Alton

#0051334

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			35,032	35,032		35,032	6,359	41,391			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,826	28,826		28,826	(32)	28,794			32
33	Real Estate Taxes			23,503	23,503		23,503		23,503			33
34	Rent-Facility & Grounds			614,500	614,500		614,500	12,289	626,789			34
35	Rent-Equipment & Vehicles							1,441	1,441			35
36	Other (specify):* <b>Replacement Tax</b>			2,026	2,026		2,026		2,026			36
37	<b>TOTAL Ownership</b>			703,887	703,887		703,887	20,057	723,944			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation			2	2		2		2			38
39	Ancillary Service Centers		189,453		189,453		189,453		189,453			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,950	285,950		285,950		285,950			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		189,453	285,952	475,405		475,405		475,405			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,756,538	644,898	3,000,929	6,402,365		6,402,365	(37,751)	6,364,614			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.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,991	30		9
10	Interest and Other Investment Income	(32)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(99)	1		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	(10,917)	21		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	(1,485)	21		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (7,542)		\$	30

**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	2	
		Amount	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)	(30,209)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (30,209)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (37,751)		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	2	3	4
		Yes	No	Amount	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				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Integrity HC of Alton

ID# 0051334

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (1,485)	21	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
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	<b>Total</b>	(1,485)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Integrity HC of Alton

# 0051334

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(99)	0	0	0	0	0	0	0	0	0	0	(99)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,600	0	0	0	0	0	0	0	0	0	3,600	5
6	Maintenance	0	660	0	0	0	0	0	0	0	0	0	660	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	(99)	4,260	0	0	0	0	0	0	0	0	0	4,161	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	0	0	0	0	0	0	0	0	0	0	0	0	16
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(296,372)	0	0	0	0	0	0	0	0	0	(296,372)	19
20	Fees, Subscriptions & Promotions	0	73	0	0	0	0	0	0	0	0	0	73	20
21	Clerical & General Office Expenses	(12,402)	219,601	0	0	0	0	0	0	0	0	0	207,199	21
22	Employee Benefits & Payroll Taxes	0	20,367	0	0	0	0	0	0	0	0	0	20,367	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,378	0	0	0	0	0	0	0	0	0	6,378	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	386	0	0	0	0	0	0	0	0	0	386	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(12,402)	(49,567)	0	0	0	0	0	0	0	0	0	(61,969)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(12,501)	(45,307)	0	0	0	0	0	0	0	0	0	(57,808)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Integrity HC of Alton# 0051334

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	4,991	1,368	0	0	0	0	0	0	0	0	0	6,359	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32)	0	0	0	0	0	0	0	0	0	0	(32)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	12,289	0	0	0	0	0	0	0	0	0	12,289	34
35	Rent-Equipment & Vehicles	0	1,441	0	0	0	0	0	0	0	0	0	1,441	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>4,959</b>	<b>15,098</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>20,057</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(7,542)</b>	<b>(30,209)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(37,751)</b>	<b>45</b>



**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
Steven Blisko	60.00%	Integrity HC of Anna	Anna	Senior Healthcare	Skokie	Management Co.
A&F General Partnership	35.00%	Integrity HC of Carbondale	Carbondale			
Ted Lerman	5.00%	Integrity HC of Chester	Chester			
		Integrity HC of Cobden	Cobden			
		Integrity HC of Columbia	Columbia			
		Integrity HC of Herring	Herrin			
		Integrity HC of Marion	Marion			

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	5 Utilities	\$	Senior Healthcare Management		\$ 3,600	\$ 3,600	1
2	V	6 Repairs		Senior Healthcare Management		660	660	2
3	V	19 Professional Services	300,000	Senior Healthcare Management		3,628	(296,372)	3
4	V	20 Licenses & Fees		Senior Healthcare Management		73	73	4
5	V	21 Office Supplies		Senior Healthcare Management		4,932	4,932	5
6	V	21 Office Expense		Senior Healthcare Management		1,258	1,258	6
7	V	21 Payroll		Senior Healthcare Management		213,411	213,411	7
8	V	22 Employee Benefits		Senior Healthcare Management		20,367	20,367	8
9	V	24 Travel/Seminar		Senior Healthcare Management		6,378	6,378	9
10	V	26 Insurance		Senior Healthcare Management		386	386	10
11	V	30 Depreciation Expense		Senior Healthcare Management		1,368	1,368	11
12	V	34 Rent Expense		Senior Healthcare Management		12,289	12,289	12
13	V	35 Equipment Lease		Senior Healthcare Management		1,441	1,441	13
14	Total		\$ 300,000			\$ 269,791	\$ * (30,209)	14

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

Facility Name & ID Number

Integrity HC of Alton

# 0051334

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

**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			Integrity HC of Belleville	Belleville				1
2			Integrity HC of Ridgway	Ridgway				2
3			Integrity HC of Godfrey	Godfrey				3
4			Integrity HC of Smithton	Smithton				4
5			Integrity HC of Wood River	Wood River				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 Integrity HC of Alton # 0051334 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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 Integrity HC of Alton

# 0051334

Report Period Beginning:

1/1/2016

Ending: 2/31/2016

**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 \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

Integrity HC of Alton

# 0051334

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	Bank Leumi	X	Working Capital	None	3/6/16	625,000	625,000	3/6/18	5.0000	28,826										
7																				
8																				
9	<b>TOTAL Facility Related</b>					\$ 625,000	\$ 625,000			\$ 28,826										
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$										
15	<b>TOTALS (line 9+line14)</b>					\$ 625,000	\$ 625,000			\$ 28,826										

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**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2015 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.)		\$	<b>54,100</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>54,100</b>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>(30,597)</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>23,503</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<b>48,634</b>	8
	2012	<b>49,362</b>	9
	2013	<b>50,159</b>	10
	2014	<b>52,415</b>	11
	2015	<b>54,100</b>	12

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2015	\$		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.**

**2015 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Integrity HC of Alton COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0051334

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>23-1-08-17-10-105-027</u>	<u>Nursing Facility</u>	\$ <u>54,100.00</u>	\$ <u>54,100.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>54,100.00</u></u>	\$ <u><u>54,100.00</u></u>

**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   X   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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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: 45,261 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 2

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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 contains 'TOTALS'.



Facility Name &amp; ID Number Integrity HC of Alton

# 0051334

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Replace Boiler	2012		12,032	209	39	309	100	1,032	9
10											10
11		Wire and Install Remote Annunciator and E-Stop	2013		1,801	31	39	46	15	154	11
12		Freezer Door, Frame, Compressor, etc.	2013		4,627	80	39	119	39	396	12
13		3lb Sandstone cove base	2013		369	6	39	9	3	31	13
14		Duro-Last Roofing System	2013		118,600	2,059	39	3,041	982	10,173	14
15		Fire Protection System / Sprinklers	2013		211,508	3,674	39	5,423	1,749	18,144	15
16		Remodeling Units 407 and 405	2013		1,964	34	39	50	16	168	16
17		Wiring for Nurse Stations and Kiosks	2013		16,539	287	39	424	137	1,418	17
18											18
19		American Boiler	2014		1,767	45	39	45		133	19
20		Kick Plates & Rub Rails	2014		432	11	39	11		33	20
21		New Ceiling & Repainting Patient Rooms	2014		13,636	350	39	350		1,035	21
22		Architect Fees	2014		2,187	56	39	56		166	22
23		Install Breakers	2014		5,230	134	39	134		397	23
24		Ceiling Repairs	2014		3,432	88	39	88		260	24
25											25
26		Flooring, cove base, paint, & wallpaper in rooms 303,									26
27		307, 308, 309, & 312, including bathrooms and hallways	2015		23,193	594	39	595	1	867	27
28											28
29		Flooring, cove base, paint, & tile in rooms 200 & 202 and three									29
30		other patient rooms including hallways, nursing station, and									30
31		bathrooms	2015		14,262	366	39	366		534	31
32											32
33		Furnish & Install two fire doors	2015		2,400	62	39	62		90	33
34		Replace main control board in transfer switch	2015		1,740	45	39	45		65	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	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	2016	\$ 8,000	\$ 95	39	\$ 95	\$	\$ 95	37	
38	2016	3,138	37	39	37		37	38	
39	2016	1,715	20	39	20		20	39	
40	2016	3,156	37	39	37		37	40	
41	2016	16,139	189	39	189		189	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)		\$ 467,867	\$ 8,509		\$ 11,551	\$ 3,042	\$ 35,474	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	\$ 140,942	\$ 24,870	\$ 28,188	\$ 3,318	5	\$ 77,583	71
72	Current Year Purchases	16,518	1,652	1,652		5	1,652	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 157,460	\$ 26,522	\$ 29,840	\$ 3,318		\$ 79,235	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 625,327	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,031	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,391	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,360	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 114,709	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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 & ID Number Integrity HC of Alton

# 0051334

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 3523 Wickenhauser, LLC

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:	<u>1971</u>	<u>181</u>	<u>1/1/16</u>	\$ <u>614,500</u>	<u>20</u>		3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>181</b>		\$ <b>614,500</b>			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 1/1/16

Ending 12/31/26

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	<u>12/31/2017</u>	\$ <u>622,635</u>
13.	<u>12/31/2018</u>	\$ <u>641,314</u>
14.	<u>12/31/2019</u>	\$ <u>660,553</u>

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  NO Terms: \_\_\_\_\_ \*

**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: \$ N/A Description: N/A

(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			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	<b>21</b>

\* 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.

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a-3	hrs		\$	4,631	\$ 296,693	\$	4,631	\$	296,693					1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			996	75,456		996		75,456					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs			5,127	250,941		5,127		250,941					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39-2	# of prescripts							167,934					167,934	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Radiology &amp; Lab</u>	39-2								21,519					21,519	12
13	Other (specify):															13
14	<b>TOTAL</b>				\$	10,754	\$ 623,090	\$	10,754	\$	189,453	\$	10,754	\$	812,543	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.

Facility Name & ID Number Integrity HC of Alton

# 0051334

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2016

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (32,271)	\$ (32,271)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,756,243	2,756,243	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	276,159	276,159	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,000,131	\$ 3,000,131	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	467,868	467,868	15
16	Equipment, at Historical Cost	157,278	157,278	16
17	Accumulated Depreciation (book methods)	(114,710)	(114,710)	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 (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 510,436	\$ 510,436	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,510,567	\$ 3,510,567	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 792,568	\$ 792,568	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	230,846	230,846	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,660	17,660	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Defer. Maint.</u>	18,990	18,990	36
37	<u>Working Capital</u>	625,000	625,000	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,685,064	\$ 1,685,064	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,685,064	\$ 1,685,064	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,825,503	\$ 1,825,503	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,510,567	\$ 3,510,567	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,815,181</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,815,181</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>110,322</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(100,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>10,322</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,825,503</b>	<b>24</b> *

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



Facility Name &amp; ID Number Integrity HC of Alton

# 0051334

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,339,735	1
2	Discounts and Allowances for all Levels	(1,232,541)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,107,194	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,238,490	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,238,490	8
<b>C. Other Operating Revenue</b>			
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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	144,042	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	21,442	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 165,484	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	32	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 32	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Vending income</u>	1,485	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,485	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,512,685	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	923,976	31
32	Health Care	2,971,231	32
33	General Administration	1,327,864	33
<b>B. Capital Expense</b>			
34	Ownership	703,887	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	189,455	35
36	Provider Participation Fee	285,950	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,402,363	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	110,322	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 110,322	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,384,559	44
45	Private Pay - Net Inpatient Revenue	905,930	45
46	Medicare - Net Inpatient Revenue	1,640,697	46
47	Other-(specify)	176,008	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,107,194	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

Facility Name & ID Number Integrity HC of Alton

# 0051334

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

**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	1,831	1,831	\$ 70,489	\$ 38.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,683	7,083	190,452	26.89	3
4	Licensed Practical Nurses	28,768	30,965	682,323	22.04	4
5	CNAs & Orderlies	75,627	81,021	916,281	11.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,956	6,557	73,348	11.19	9
10	Activity Assistants					10
11	Social Service Workers	3,471	3,755	52,266	13.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,103	18,283	194,198	10.62	15
16	Dishwashers					16
17	Maintenance Workers	3,056	3,430	55,305	16.12	17
18	Housekeepers	12,709	13,540	125,364	9.26	18
19	Laundry	7,581	8,188	70,814	8.65	19
20	Administrator	2,145	2,291	88,596	38.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,247	4,524	61,214	13.53	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	2,223	2,378	33,418	14.05	31
32	Other Health C: <u>MDS</u>	3,292	3,583	95,922	26.77	32
33	Other(specify) <u>Admission Coord</u>	2,013	2,167	46,548	21.48	33
34	TOTAL (lines 1 - 33)	176,705	189,596	\$ 2,756,538 *	\$ 14.54	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	248	\$ 8,684	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	842	29,472	10-3	38
39	Pharmacist Consultant	173	8,630	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	121	4,234	12-3	45
46	Other(specify) <u>MDS Consultant</u>	477	16,697	10-3	46
47	<u>HR Comp Consultant</u>	192	9,580	21-3	47
48	<u>Marketing Consultant</u>	135	6,758	21-3	48
49	TOTAL (lines 35 - 48)	2,188	\$ 84,055		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Laura Northway	Administrator		\$ 79,042	Workers' Compensation Insurance	\$ 93,544	IDPH License Fee	\$	
Ashley Cline	Administrator		9,554	Unemployment Compensation Insurance	70,204	Advertising: Employee Recruitment		
				FICA Taxes	206,636	Health Care Worker Background Check		
				Employee Health Insurance	118,098	(Indicate # of checks performed )		
				Employee Meals		Various	513	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council of LT Care	4,200	
				Employee Expense	18,155	Ehealth Data	900	
						Riverbend Growth Assoc.	1,088	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 88,596</b>			Secretary of State	370	
(List each licensed administrator separately.)						Madison County Health	375	
						Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
				<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ 506,637</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ 7,446</b>	
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Auto Allowance	8,505
							Mileage	3,382
							Mgmt Lodging and fuel	6,377
							Seminar Expense	
							Education	80
							Entertainment Expense	( )
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$</b>	<b>TOTAL</b>		<b>\$</b>	(agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)							<b>TOTAL</b>	<b>\$ 18,344</b>
<b>C. Professional Services</b>								
Vendor/Payee	Type		Amount					
Polsinelli	Legal Fees		\$ 188					
Segal McCambridge & Mahoney	Legal Fees		220					
Bradley Associates	Accounting Fees		7,702					
Johnson, Goldberg & Brown	Accounting Fees		3,000					
Senior Healthcare	Mgmt/Professional Fees		300,000					
Sandberg Phoenix & Von Gontard P.	Collections		9,649					
Senior Management	Professional Fees		4,164					
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 324,923</b>					
(For legal fee disclosure, see page 39 of instructions)								

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number Integrity HC of Alton

# 0051334

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ILLINOIS COUNCIL - 4,200
- (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. \$ 17,851 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. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? X YES \_\_\_\_\_ 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.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 285,950  
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? N/A
- (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? N/A 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 benefit on Schedule V. \$ NONE Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (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? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100%  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
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. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: N/A
- (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. YES  
Attach invoices and a summary of services for all architect and appraisal fees