

		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>I. IDPH License ID Number: <u>0051342</u></p> <p>Facility Name: <u>Integrity HC of Belleville</u></p> <p>Address: <u>727 North 17th St</u> <u>Belleville</u> <u>62226</u> <small>Number City Zip Code</small></p> <p>County: <u>St Clair</u></p> <p>Telephone Number: <u>(708) 236-0000</u> Fax # <u>(708) 236-0001</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03/01/11</u></p> <p>Type of Ownership:</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 IRS Exemption Code _____ </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>In the event there are further questions about this report, please contact: Name: <u>Daniel S. Gaafar</u> Telephone Number: <u>(317) 237-5500</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</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="width:20%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (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> Fax # <u>(317) 237-5503</u> </td> </tr> </table> <p align="right"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </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> Fax # <u>(317) 237-5503</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<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> Fax # <u>(317) 237-5503</u>							

Facility Name & ID Number Integrity HC of Belleville

0051342 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	135	Skilled (SNF)	135	49,410	1
2		Skilled Pediatric (SNF/PED)			2
3	45	Intermediate (ICF)	45	16,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,880	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	21,369	581	894	22,844	8
9	SNF/PED					9
10	ICF	7,123	194	0	7,317	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,492	775	894	30,161	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.78%

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 03/02/11

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

YES Date 03/02/11 NO

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

YES NO If YES, enter number of beds certified 135 and days of care provided 894

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 Belleville # 0051342 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
	A. General Services										
1	Dietary	200,067	12,246	6,797	219,110		219,110	(20)	219,090		1
2	Food Purchase		159,892		159,892		159,892		159,892		2
3	Housekeeping	130,028	18,120		148,148		148,148		148,148		3
4	Laundry	95,355	8,781		104,136		104,136		104,136		4
5	Heat and Other Utilities			213,440	213,440		213,440	3,600	217,040		5
6	Maintenance	57,669	16,185	38,047	111,901		111,901	660	112,561		6
7	Other (specify):*										7
8	TOTAL General Services	483,119	215,224	258,284	956,627		956,627	4,240	960,867		8
	B. Health Care and Programs										
9	Medical Director			36,000	36,000		36,000		36,000		9
10	Nursing and Medical Records	1,786,895	113,234	45,760	1,945,889		1,945,889		1,945,889		10
10a	Therapy	46,134	10,878	259,981	316,993		316,993		316,993		10a
11	Activities	82,275	2,996		85,271		85,271		85,271		11
12	Social Services	51,043		6,849	57,892		57,892		57,892		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Rx consultant			7,714	7,714		7,714		7,714		15
16	TOTAL Health Care and Programs	1,966,347	127,108	356,304	2,449,759		2,449,759		2,449,759		16
	C. General Administration										
17	Administrative	93,276			93,276		93,276		93,276		17
18	Directors Fees										18
19	Professional Services			396,765	396,765		396,765	(296,372)	100,393		19
20	Dues, Fees, Subscriptions & Promotions			9,509	9,509		9,509	73	9,582		20
21	Clerical & General Office Expenses	98,094	25,911	56,007	180,012		180,012	218,753	398,765		21
22	Employee Benefits & Payroll Taxes			355,476	355,476		355,476	20,367	375,843		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,286	6,286		6,286	6,378	12,664		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			239,906	239,906		239,906	386	240,292		26
27	Other (specify):*										27
28	TOTAL General Administration	191,370	25,911	1,063,949	1,281,230		1,281,230	(50,415)	1,230,815		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,640,836	368,243	1,678,537	4,687,616		4,687,616	(46,175)	4,641,441		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Integrity HC of Belleville

#0051342

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	
	D. Ownership											
30	Depreciation			36,227	36,227		36,227	8,460	44,687			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			34,456	34,456		34,456	(562)	33,894			32
33	Real Estate Taxes			67,607	67,607		67,607		67,607			33
34	Rent-Facility & Grounds			423,150	423,150		423,150	12,289	435,439			34
35	Rent-Equipment & Vehicles							1,441	1,441			35
36	Other (specify):*											36
37	TOTAL Ownership			561,440	561,440		561,440	21,628	583,068			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			508	508		508		508			38
39	Ancillary Service Centers		51,129		51,129		51,129		51,129			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			275,864	275,864		275,864		275,864			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		51,129	276,372	327,501		327,501		327,501			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,640,836	419,372	2,516,349	5,576,557		5,576,557	(24,547)	5,552,010			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	7,092	30		9
10	Interest and Other Investment Income	(562)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	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	8,750	21		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	(8,777)	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	(821)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 5,662		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$ (30,209)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (24,547)		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		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Integrity HC of Belleville

ID# 0051342

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (821)	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	Total	(821)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Integrity HC of Belleville

0051342

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	(20)	0	0	0	0	0	0	0	0	0	0	(20)	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	TOTAL General Services	(20)	4,260	0	0	0	0	0	0	0	0	0	4,240	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
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	(848)	219,601	0	0	0	0	0	0	0	0	0	218,753	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	TOTAL General Administration	(848)	(49,567)	0	0	0	0	0	0	0	0	0	(50,415)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(868)	(45,307)	0	0	0	0	0	0	0	0	0	(46,175)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Integrity HC of Belleville

0051342

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,092	1,368	0	0	0	0	0	0	0	0	0	8,460	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(562)	0	0	0	0	0	0	0	0	0	0	(562)	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	TOTAL Ownership	6,530	15,098	0	0	0	0	0	0	0	0	0	21,628	37
	Ancillary Expense													
	E. Special Cost Centers													
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	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,662	(30,209)	0	0	0	0	0	0	0	0	0	(24,547)	45

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 Alton	Alton	Senior Healthcare	Skokie	Management Co.
A&F General Partnership	35.00%	Integrity HC of Anna	Anna			
Ted Lerman	5.00%	Integrity HC of Carbondale	Carbondale			
		Integrity HC of Chester	Chester			
		Integrity HC of Cobden	Cobden			
		Integrity HC of Columbia	Columbia			
		Integrity HC of Herrin	Herrin			

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 - Other	\$	Senior Healthcare Management		\$ 3,600	\$ 3,600	1
2	V	6 Maintenance Supplies		Senior Healthcare Management		660	660	2
3	V	19 Professional Fees	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 Expenses		Senior Healthcare Management		1,258	1,258	6
7	V	21 Office Wages		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		Senior Healthcare Management		1,368	1,368	11
12	V	34 Facility Rent		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 Belleville

0051342

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 Marion	Marion				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 Belleville # 0051342 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 Belleville

0051342

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Integrity HC of Belleville

0051342

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			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Bank Leumi	X	Working Capital	None	3/4/15	1,500,000	1,350,000	3/6/18	5.0000	6,766										
7	LTC Funding	X	Working Capital	None	Various	5,525,000	5,525,000		Various	27,690										
8																				
9	TOTAL Facility Related					7,025,000	6,875,000			34,456										
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)					7,025,000	6,875,000			34,456										

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.		\$	56,578	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.)		\$	48,608	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,971)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	75,577	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	67,607	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2011	65,136	8	
	2012	46,250	9	
	2013	16,190	10	
	2014	47,016	11	
	2015	48,608	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 Belleville COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0051342

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>08-20.0-211-030</u>	<u>Nursing Facility</u>	\$ <u>48,607.50</u>	\$ <u>48,607.50</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>48,607.50</u></u>	\$ <u><u>48,607.50</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: 52,326 B. General Construction Type: Exterior Brick Frame Concrete 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 for row numbers. Row 1: Use, Square Feet, Year Acquired, Cost, 1. Row 2: Use, Square Feet, Year Acquired, Cost, 2. Row 3: TOTALS, Square Feet, Year Acquired, Cost, 3.

Facility Name & ID Number Integrity HC of Belleville

0051342

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
	Improvement Type**										
9		Gas Water Heater		2011	5,720		39			5,720	9
10											10
11		Install Outlets		2012	33,491	859	39	859		4,295	11
12											12
13		Installation of New Fire Protection Sprinkler System		2013	242,880	6,228	39	6,228		31,140	13
14		Pave Driveway, Build New Ramp w/ Door		2013	4,348	111	39	111		398	14
15		Electrical Installations / Generator Upgrade		2013	17,353	445	39	445		1,557	15
16		Wiring for Nurse Stations and Kiosks		2013	18,920	485	39	485		1,698	16
17											17
18		Electrical installation		2014	2,700	69	39	69		207	18
19		Elevator Door Protection Devices		2014	5,435	140	39	140		420	19
20		Elevator Repair		2014	2,500	64	39	64		192	20
21											21
22		Install elevator door restrictor assembly		5/19/2015	2,850	73	39	73	(0)	116	22
23		Resident room number signs		6/22/2015	5,700	146	39	146	(0)	219	23
24		Install and hook up new boiler unit		7/8/2015	13,855	355	39	355	(0)	533	24
25		Supplies/labor to fix broken elevator		7/11/2015	4,541	116	39	116	(0)	174	25
26											26
27		Remove damaged elevator components, new door									27
28		operator assembly, new door hanger track & rollers,									28
29		new car door clutch assembly & gate switch assembly,									29
30		clean and straighten damaged door panels, labor		7/21/2015	32,200	826	39	827	1	1,172	30
31											31
32		Install elevator pit light to correct state violation		7/2/2015	1,217	31	39	31	(0)	47	32
33		Repair non-working elevator doors		7/28/2015	1,219	31	39	31	(0)	44	33
34		Emergency overtime elevator repairs		7/28/2015	1,632	42	39	42	0	59	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	2	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	Building modification due to state survey to Rm 315/410, which	2016	\$ 58,475	\$ 687	39	\$ 991	\$ 304	\$ 687	37
38	included:	2016							38
39	Customized bed	2016							39
40	Enlarging door ways and installing walls and doors in patient r	2016							40
41	Electrical work, construction of walls and ramps	2016							41
42	Heavy Duty Low Air Loss Mattress	2016							42
43	Heavy Duty Low Air Loss Mattress	2016							43
44	Structural assessment	2016							44
45	Electrical work for patient rooms, nurse call wiring	2016							45
46	Labor to remove and transfer resident	2016							46
47	Aluminum door/labor	2016							47
48									48
49	Storage tank replacement	2016	8,385	98		125	27	98	49
50	Bus repairs - repair lift that would not stow	2016	3,727	44		56	12	44	50
51	Fixed water lines in basement storage tank under dietary	2016	1,368	16		18	2	16	51
52	Removal and replacement of 5 ton condensing unit on the roof	2016	5,945	70		51	(19)	70	52
53	and hanging air handler in the kitchen								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)		\$ 474,461	\$ 10,937		\$ 11,263	\$ 326	\$ 48,906	70

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

Facility Name & ID Number Integrity HC of Belleville

0051342

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	\$ 146,866	\$ 23,264	\$ 29,373	\$ 6,109	5	\$ 90,154	71
72	Current Year Purchases	20,256	2,026	4,051	2,025	5	2,027	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 167,122	\$ 25,290	\$ 33,424	\$ 8,134		\$ 92,181	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)	\$ 641,583	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,227	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,687	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,461	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 141,087	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 727 North 17th Street, 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>1969</u>	<u>180</u>	<u>3/1/11</u>	\$ <u>423,150</u>	<u>20</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		180		\$ 423,150			7

10. Effective dates of current rental agreement:

Beginning 3/1/11

Ending 2/28/31

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/17</u>	\$ <u>435,845</u>
13.	<u>12/31/18</u>	\$ <u>448,920</u>
14.	<u>12/31/19</u>	\$ <u>462,387</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

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: _____

(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	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.

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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	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			1,524	\$ 94,477					1,524	\$ 94,477			1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			637	39,690					637	39,690			2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs			3,027	125,814					3,027	125,814			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							44,404			44,404			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Radiology & Lab</u>	39-2								6,725			6,725			12
13	Other (specify):															13
14	TOTAL				\$	5,188	\$ 259,981	\$	51,129	\$	5,188	\$	311,110			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	\$ (43,020)	\$ (43,020)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,725,530	1,725,530	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	258,581	258,581	6
7	Other Prepaid Expenses	71,000	71,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,012,091	\$ 2,012,091	10
	B. Long-Term Assets			
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	544,240	544,240	15
16	Equipment, at Historical Cost	172,842	172,842	16
17	Accumulated Depreciation (book methods)	(141,085)	(141,085)	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 575,997	\$ 575,997	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,588,088	\$ 2,588,088	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 721,196	\$ 721,196	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,129	214,129	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,381	16,381	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 951,706	\$ 951,706	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,875,000	6,875,000	39
40	Mortgage Payable			40
41	Bonds Payable			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)	\$ 6,875,000	\$ 6,875,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,826,706	\$ 7,826,706	46
47	TOTAL EQUITY(page 18, line 24)	\$ (5,238,618)	\$ (5,238,618)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,588,088	\$ 2,588,088	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,119,616)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,119,616)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,119,002)	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)	\$ (1,119,002)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (5,238,618)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Integrity HC of Belleville

0051342

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,290,604	1
2	Discounts and Allowances for all Levels	(384,111)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,906,493	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	516,117	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 516,117	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,204	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,355	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 33,559	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	562	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 562	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	821	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 821	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,457,552	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	956,625	31
32	Health Care	2,449,759	32
33	General Administration	1,281,230	33
B. Capital Expense			
34	Ownership	561,439	34
C. Ancillary Expense			
35	Special Cost Centers	51,637	35
36	Provider Participation Fee	275,864	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,576,554	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,119,002)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,119,002)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,815,110	44
45	Private Pay - Net Inpatient Revenue	69,074	45
46	Medicare - Net Inpatient Revenue	402,119	46
47	Other-(specify)	(379,811)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,906,492	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 Belleville

0051342

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	1,950	2,112	\$ 92,422	\$ 43.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,359	1,413	34,910	24.71	3
4	Licensed Practical Nurses	34,595	36,468	845,830	23.19	4
5	CNAs & Orderlies	63,825	67,162	673,305	10.03	5
6	CNA Trainees					6
7	Licensed Therapist	1,870	2,113	46,134	21.83	7
8	Rehab/Therapy Aides					8
9	Activity Director	6,352	6,887	82,275	11.95	9
10	Activity Assistants					10
11	Social Service Workers	2,837	2,961	51,043	17.24	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,890	17,188	200,067	11.64	15
16	Dishwashers					16
17	Maintenance Workers	3,918	4,209	57,669	13.70	17
18	Housekeepers	12,225	12,904	130,028	10.08	18
19	Laundry	9,147	9,875	95,355	9.66	19
20	Administrator	1,831	2,348	93,276	39.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,495	4,931	58,441	11.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,872	2,121	42,574	20.07	31
32	Other Health C: Admissions	1,828	2,068	39,653	19.17	32
33	Other(specify) <u>MDS</u>	3,108	3,346	97,854	29.25	33
34	TOTAL (lines 1 - 33)	167,102	178,106	\$ 2,640,836 *	\$ 14.83	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	194	\$ 6,797	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	814	28,482	10-3	38
39	Pharmacist Consultant	154	7,714	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	196	6,849	12-3	45
46	Other(specify) <u>MDS Consultant</u>	494	17,278	10-3	46
47	<u>HR Corp Compliance</u>	191	9,550	21-3	47
48	<u>Marketing Consultant</u>	144	7,197	21-3	48
49	TOTAL (lines 35 - 48)	2,187	\$ 83,867		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			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Mike Olsen	Administrator		\$ 73,824	Workers' Compensation Insurance	\$ 59,618	IDPH License Fee	\$	
Mary Garcia	Administrator		19,452	Unemployment Compensation Insurance	62,767	Advertising: Employee Recruitment		
				FICA Taxes	186,627	Health Care Worker Background Check		
				Employee Health Insurance	60,045	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council of LTC	4,200	
				Employee Expense	6,786	IL Office of the State Fire Marshall	125	
						IL Dept of Public Health	3,980	
TOTAL (agree to Schedule V, line 17, col. 1)						CMS	554	
(List each licensed administrator separately.)			\$ 93,276			Various	723	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
			\$			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$ 375,843	TOTAL (agree to Sch. V,	\$ 9,582	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Daniel Maher Law Offices	Legal Fees		\$ 8,900			\$	Out-of-State Travel	\$
Sandbery Phoenix & Von Gontard	Legal Fees		59,100					
Polsinelli PC	Legal Fees		22,176					
Segal McCambridge & Mahoney	Legal Fees		1,147				In-State Travel	
Sprague & Urban - RL	Legal Fees		3,638				Auto Allowance	5,172
Michigan Peer Review Org	Legal Fees		1,418				Mileage Reimbursement	909
Bradley Associates	Accounting Fees		7,649				Management Lodging & Gasoline	6,378
Johnson Goldberg & Brown	Accounting Fees		3,000				Seminar Expense	
Senior Healthcare	Mgmt/Professional Fees		300,000				Education	205
Polsinelli PC	Professional Fees		(10,263)					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)			\$ 396,765				(agree to Sch. V,	

* Attach copy of IMRF notifications

**See instructions.

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. \$ 8,845 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? 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. \$ 275,864
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 benefits 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? 0
 - 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? 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? 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