



Facility Name & ID Number Integrity HC of Cobden

# 0051003 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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	16	Skilled (SNF)	16	5,840	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	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	3,587	403	1,292	5,282	8
9	SNF/PED					9
10	ICF	13,019	1,461	1,441	15,921	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,606	1,864	2,733	21,203	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.50%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
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 06/01/10

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 06/01/10 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 10 and days of care provided 895

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Integrity HC of Cobden # 0051003 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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	128,552	10,939	5,577	145,068		145,068	(54)	145,014		1
2	Food Purchase		123,974		123,974		123,974		123,974		2
3	Housekeeping	92,372	10,180		102,552		102,552		102,552		3
4	Laundry	39,939	6,605		46,544		46,544		46,544		4
5	Heat and Other Utilities			78,027	78,027		78,027	1,826	79,853		5
6	Maintenance	20,660	16,005	23,750	60,415		60,415	233	60,648		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	281,523	167,703	107,354	556,580		556,580	2,005	558,585		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,680	12,680		12,680		12,680		9
10	Nursing and Medical Records	601,438	57,244	281,705	940,387		940,387		940,387		10
10a	Therapy			213,168	213,168		213,168		213,168		10a
11	Activities	32,868	3,184		36,052		36,052		36,052		11
12	Social Services	40,518		4,695	45,213		45,213		45,213		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Pharmacy Consultant</b>			6,336	6,336		6,336		6,336		15
16	<b>TOTAL Health Care and Programs</b>	674,824	60,428	518,584	1,253,836		1,253,836		1,253,836		16
	<b>C. General Administration</b>										
17	Administrative	58,172			58,172		58,172		58,172		17
18	Directors Fees										18
19	Professional Services			188,622	188,622		188,622	(167,239)	21,383		19
20	Dues, Fees, Subscriptions & Promotions			8,292	8,292		8,292	79	8,371		20
21	Clerical & General Office Expenses	36,246	22,579	56,588	115,413		115,413	116,916	232,329		21
22	Employee Benefits & Payroll Taxes			161,687	161,687		161,687	10,226	171,913		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,061	8,061		8,061	4,142	12,203		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			78,900	78,900		78,900	18	78,918		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	94,418	22,579	502,150	619,147		619,147	(35,857)	583,290		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,050,765	250,710	1,128,088	2,429,563		2,429,563	(33,852)	2,395,711		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 Cobden

#0051003

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			15,292	15,292		15,292	(1)	15,291		30
31	Amortization of Pre-Op. & Org.			815	815		815		815		31
32	Interest			39,036	39,036		39,036	(241)	38,795		32
33	Real Estate Taxes			27,534	27,534		27,534		27,534		33
34	Rent-Facility & Grounds			190,052	190,052		190,052	7,781	197,833		34
35	Rent-Equipment & Vehicles							768	768		35
36	Other (specify):* Replacement Tax			4,663	4,663		4,663	(4,663)			36
37	<b>TOTAL Ownership</b>			277,392	277,392		277,392	3,644	281,036		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		47,261		47,261		47,261		47,261		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			163,511	163,511		163,511		163,511		42
43	Other (specify):*			2,213	2,213		2,213	(2,213)			43
44	<b>TOTAL Special Cost Centers</b>		47,261	165,724	212,985		212,985	(2,213)	210,772		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,050,765	297,971	1,571,204	2,919,940		2,919,940	(32,421)	2,887,519		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	(1)	30		9
10	Interest and Other Investment Income	(241)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(54)	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	(4,278)	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	(2,213)	43		24
25	Fund Raising, Advertising and Promotional	(14,301)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,663)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (25,751)		\$	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)	(6,670)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (6,670)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (32,421)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY							
48		49		50		51	52

Integrity HC of Cobden

ID# 0051003

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
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			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>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Integrity HC of Cobden

# 0051003

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	(54)	0	0	0	0	0	0	0	0	0	0	(54)	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	1,826	0	0	0	0	0	0	0	0	0	1,826	5
6	Maintenance	0	233	0	0	0	0	0	0	0	0	0	233	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(54)</b>	<b>2,059</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>2,005</b>	<b>8</b>
	<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>	<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>16</b>
	<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	(167,239)	0	0	0	0	0	0	0	0	0	(167,239)	19
20	Fees, Subscriptions & Promotions	0	79	0	0	0	0	0	0	0	0	0	79	20
21	Clerical & General Office Expenses	(18,579)	135,495	0	0	0	0	0	0	0	0	0	116,916	21
22	Employee Benefits & Payroll Taxes	0	10,226	0	0	0	0	0	0	0	0	0	10,226	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,142	0	0	0	0	0	0	0	0	0	4,142	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	18	0	0	0	0	0	0	0	0	0	18	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(18,579)</b>	<b>(17,278)</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>(35,857)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(18,633)</b>	<b>(15,219)</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>(33,852)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Integrity HC of Cobden

# 0051003

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1)	0	0	0	0	0	0	0	0	0	0	(1)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(241)	0	0	0	0	0	0	0	0	0	0	(241)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	7,781	0	0	0	0	0	0	0	0	0	7,781	34
35	Rent-Equipment & Vehicles	0	768	0	0	0	0	0	0	0	0	0	768	35
36	Other (specify):*	(4,663)	0	0	0	0	0	0	0	0	0	0	(4,663)	36
37	<b>TOTAL Ownership</b>	<b>(4,905)</b>	<b>8,549</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>3,644</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):*	(2,213)	0	0	0	0	0	0	0	0	0	0	(2,213)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(2,213)</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>(2,213)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(25,751)</b>	<b>(6,670)</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>(32,421)</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 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 Chester	Chester			
		Integrity HC of Carbondale	Carbondale			
		Integrity HC of Columbia	Columbia			
		Integrity HC of Herrin	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	\$			\$ 1,826	\$ 1,826	1
2	V	6 Repairs				233	233	2
3	V	19 Professional Services	167,500			261	(167,239)	3
4	V	20 Licenses & Fees				79	79	4
5	V	21 Office Supplies				2,631	2,631	5
6	V	21 Office Expense				812	812	6
7	V	21 Payroll				132,052	132,052	7
8	V	22 Employee Benefits				10,226	10,226	8
9	V	24 Travel/Seminar				4,142	4,142	9
10	V	26 Insurance				18	18	10
11	V	34 Rent Expense				7,781	7,781	11
12	V	35 Equipment Lease				768	768	12
13	V							13
14	Total		\$ 167,500			\$ 160,830	\$ * (6,670)	14

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

Facility Name & ID Number

Integrity HC of Cobden

# 0051003

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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 Belleville	Belleville				2
3			Integrity HC of Ridgway	Ridgway				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 Cobden # 0051003 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Cobden

# 0051003

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

**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 Cobden

# 0051003

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	3/06/18	4,500,000	260,000	3/6/18	5.7500	39,036										
7																				
8																				
9	<b>TOTAL Facility Related</b>					\$ 4,500,000	\$ 260,000			\$ 39,036										
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12																				
13																				
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$										
15	<b>TOTALS (line 9+line14)</b>					\$ 4,500,000	\$ 260,000			\$ 39,036										

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 2016 report.		\$	<b>41,214</b>	<b>1</b>
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>21,558</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(19,656)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>47,190</b>	<b>4</b>
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>		\$		<b>5</b>
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>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>27,534</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2012	<b>20,607</b>	<b>8</b>	
	2013	<b>21,111</b>	<b>9</b>	
	2014	<b>21,542</b>	<b>10</b>	
	2015	<b>21,400</b>	<b>11</b>	
	2016	<b>21,558</b>	<b>12</b>	
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**



X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_

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: 12,225 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 815 4. Dates Incurred: Prior to 06/01/10

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3



**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	Fire Panels		2011	7,852	201	39	201		1,256	9
10	Sprinklers		2011	154,499	3,962	39	3,962		25,093	10
11	Guard Rails		2011	18,200	467	39	467		2,958	11
12	Roof Repairs		2012	61,000	1,564	39	1,564		9,319	12
13	Renovation (painting, tile, carpet, overhead lights,cabinets,									13
14	new doors/hardware, replace sidewalk in dining room,									14
15	kitchen, bathrooms, resident rooms, activity room, etc.		2013	155,368	3,984	39	3,984		19,588	15
16	Wiring Nurse Stations and Kiosks		2013	11,039	283	39	283		1,226	16
17										17
18	Labor to install alarm system		2015	986	25	39	25		62	18
19	Installation of alarm system		2015	1,003	26	39	26		64	19
20	1,596 sq. yrds of hot-mix asphalt		2015	23,394	600	39	600		1,474	20
21	Install safety glass windows to doors		2015	850	22	39	22		54	21
22	260 ft of pvc/vinyl fence and 3 gates		2015	12,522	321	39	321		789	22
23	Door with hinges, closer, panic exit		2015	3,880	99	39	99		244	23
24										24
25	Compressor		2016	2,171	56	39	56		88	25
26	Exhaust Fan		2016	1,527	39	39	39		55	26
27	Utility Room water leak repair		2016	1,485	38	39	38		51	27
28										28
29	Laundry unit system		2017	3,633	47	39	47		47	29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 459,409	\$ 11,734		\$ 11,734	\$	\$ 62,368	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	\$ 15,897	\$ 3,180	\$ 3,179	\$ (1)	5	\$ 9,615	71
72	Current Year Purchases	3,774	378	378		5	378	72
73	Fully Depreciated Assets	14,273					14,273	73
74								74
75	TOTALS	\$ 33,944	\$ 3,558	\$ 3,557	\$ (1)		\$ 24,266	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)	\$ 493,353	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,292	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,291	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 86,634	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 Cobden

# 0051003

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: 430 South Front 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:	1995	74	10/1/15	\$ 190,052	20	N/A	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		74		\$ 190,052			7

10. Effective dates of current rental agreement:

Beginning 10/1/15

Ending 9/30/25

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

Fiscal Year Ending                      Annual Rent

12.	<u>12/31/18</u>	\$ <u>231,826</u>
13.	<u>12/31/19</u>	\$ <u>238,779</u>
14.	<u>12/31/20</u>	\$ <u>245,946</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: 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>		\$	\$	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	<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)	
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		\$	1,645	\$ 97,907	\$	1,645	\$	97,907					1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			506	35,548		506		35,548					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs			1,885	79,713		1,885		79,713					4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	10a-3	# of prescrpts							40,004					40,004	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Radiology &amp; Lab</u>									7,257					7,257	12
13	Other (specify): _____															13
14	<b>TOTAL</b>				\$	4,036	\$ 213,168	\$	4,036	\$	47,261	\$	4,036	\$	260,429	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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (2,960)	\$ (2,960)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,391,106	1,391,106	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,778	114,778	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>	\$ 1,502,924	\$ 1,502,924	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	459,408	459,408	15
16	Equipment, at Historical Cost	33,944	33,944	16
17	Accumulated Depreciation (book methods)	(86,635)	(86,635)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,180)	(6,180)	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>	\$ 412,762	\$ 412,762	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,915,686	\$ 1,915,686	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 438,883	\$ 438,883	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,778	114,778	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,781	8,781	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 562,442	\$ 562,442	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	260,000	260,000	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>	\$ 260,000	\$ 260,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 822,442	\$ 822,442	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,093,244	\$ 1,093,244	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,915,686	\$ 1,915,686	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>1,010,735</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>1,010,735</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>82,509</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>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>82,509</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>1,093,244</b>	<b>24</b> *

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



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**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required****classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,861,701	1
2	Discounts and Allowances for all Levels	(313,714)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,547,987	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	416,486	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 416,486	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	34,189	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,546	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 37,735	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	241	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 241	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,002,449	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	556,580	31
32	Health Care	1,253,835	32
33	General Administration	619,147	33
<b>B. Capital Expense</b>			
34	Ownership	277,392	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	47,262	35
36	Provider Participation Fee	163,511	36
<b>D. Other Expenses (specify):</b>			
37	Bad Debt	2,213	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,919,940	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	82,509	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 82,509	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,608,601	44
45	Private Pay - Net Inpatient Revenue	232,074	45
46	Medicare - Net Inpatient Revenue	424,245	46
47	Other-(specify)	283,068	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,547,988	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.

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**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	1,896	2,104	\$ 56,468	\$ 26.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,494	3,842	96,778	25.19	3
4	Licensed Practical Nurses	8,465	9,222	176,014	19.09	4
5	CNAs & Orderlies	19,027	20,919	232,612	11.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,730	3,063	32,868	10.73	10
11	Social Service Workers	3,285	3,577	40,518	11.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,847	13,849	128,552	9.28	15
16	Dishwashers					16
17	Maintenance Workers	1,194	1,217	20,660	16.98	17
18	Housekeepers	9,908	10,930	92,372	8.45	18
19	Laundry	4,246	4,618	39,939	8.65	19
20	Administrator	2,392	2,528	58,172	23.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,523	1,647	22,513	13.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Admission Coordi</u>	929	1,010	13,733	13.60	32
33	Other(specify) <u>MDS</u>	1,848	2,020	39,566	19.59	33
34	TOTAL (lines 1 - 33)	73,784	80,546	\$ 1,050,765 *	\$ 13.05	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	159	\$ 5,577	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	727	25,455	10-3	38
39	Pharmacist Consultant	127	6,336	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	134	4,695	12-3	45
46	Other(specify) <u>MDS Consultant</u>	347	12,134	10-3	46
47	<u>HR Corp Compliance</u>	357	17,860	21-3	47
48	<u>Marketinc Consultant</u>	161	8,045	21-3	48
49	TOTAL (lines 35 - 48)	2,012	\$ 80,102		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



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**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. \$ 12,965 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. \$ 163,511  
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? N/A 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