

Facility Name & ID Number Integrity HC of Smithton

0053298 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	101	Intermediate (ICF)	101	36,865	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	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					8
9	SNF/PED					9
10	ICF	27,654	860	876	29,390	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,654	860	876	29,390	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.72%

D. How many bed reserve days during this year were paid by the Department? NONE (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES 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 11/24/14

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/24/14 NO

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

Medicare Intermediary N/A

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 Smithton # 0053298 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
	A. General Services										
1	Dietary	152,770	12,514	5,695	170,979		170,979		170,979		1
2	Food Purchase		163,148		163,148		163,148	(24)	163,124		2
3	Housekeeping			87,929	87,929		87,929		87,929		3
4	Laundry		5,863	58,620	64,483		64,483		64,483		4
5	Heat and Other Utilities			108,637	108,637		108,637	1,826	110,463		5
6	Maintenance	23,948	16,647	27,771	68,366		68,366	233	68,599		6
7	Other (specify):*										7
8	TOTAL General Services	176,718	198,172	288,652	663,542		663,542	2,035	665,577		8
	B. Health Care and Programs										
9	Medical Director			19,000	19,000		19,000		19,000		9
10	Nursing and Medical Records	1,055,081	53,056	230,475	1,338,612		1,338,612		1,338,612		10
10a	Therapy			12,088	12,088		12,088		12,088		10a
11	Activities	48,365	5,748		54,113		54,113		54,113		11
12	Social Services	122,450		6,293	128,743		128,743		128,743		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Pharmacy Consultant			8,982	8,982		8,982		8,982		15
16	TOTAL Health Care and Programs	1,225,896	58,804	276,838	1,561,538		1,561,538		1,561,538		16
	C. General Administration										
17	Administrative	48,933			48,933		48,933		48,933		17
18	Directors Fees										18
19	Professional Services			180,644	180,644		180,644	(167,239)	13,405		19
20	Dues, Fees, Subscriptions & Promotions			8,052	8,052		8,052	79	8,131		20
21	Clerical & General Office Expenses	25,912	34,263	63,410	123,585		123,585	119,312	242,897		21
22	Employee Benefits & Payroll Taxes			251,219	251,219		251,219	10,226	261,445		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,566	2,566		2,566	4,142	6,708		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			87,900	87,900		87,900	18	87,918		26
27	Other (specify):*										27
28	TOTAL General Administration	74,845	34,263	593,791	702,899		702,899	(33,462)	669,437		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,477,459	291,239	1,159,281	2,927,979		2,927,979	(31,427)	2,896,552		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 Smithton

#0053298

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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			9,565	9,565		9,565		9,565			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,412	37,412		37,412	(235)	37,177			32
33	Real Estate Taxes			37,245	37,245		37,245		37,245			33
34	Rent-Facility & Grounds			209,032	209,032		209,032	7,781	216,813			34
35	Rent-Equipment & Vehicles							768	768			35
36	Other (specify):* Replacement Tax			2,194	2,194		2,194	(2,194)				36
37	TOTAL Ownership			295,448	295,448		295,448	6,120	301,568			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,397		9,397		9,397		9,397			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			234,084	234,084		234,084		234,084			42
43	Other (specify):* Bad Debt			46,328	46,328		46,328	(46,328)				43
44	TOTAL Special Cost Centers		9,397	280,412	289,809		289,809	(46,328)	243,481			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,477,459	300,636	1,735,141	3,513,236		3,513,236	(71,635)	3,441,601			45

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

Integrity HC of Smithton

ID# 0053298

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (945)	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	(945)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Integrity HC of Smithton

0053298

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(24)	0	0	0	0	0	0	0	0	0	0	(24)	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	TOTAL General Services	(24)	2,059	0	0	0	0	0	0	0	0	0	2,035	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	(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	(16,183)	135,495	0	0	0	0	0	0	0	0	0	119,312	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	TOTAL General Administration	(16,183)	(17,279)	0	0	0	0	0	0	0	0	0	(33,462)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,207)	(15,220)	0	0	0	0	0	0	0	0	0	(31,427)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Integrity HC of Smithton # 0053298 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	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(235)	0	0	0	0	0	0	0	0	0	0	(235) 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):*	(2,194)	0	0	0	0	0	0	0	0	0	0	(2,194) 36
37	TOTAL Ownership	(2,429)	8,549	0	0	0	0	0	0	0	0	0	6,120 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):*	(46,328)	0	0	0	0	0	0	0	0	0	0	(46,328) 43
44	TOTAL Special Cost Centers	(46,328)	0	0	0	0	0	0	0	0	0	0	(46,328) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(64,964)	(6,671)	0	0	0	0	0	0	0	0	0	(71,635) 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	Integrity HC of Anna	Anna	Senior Healthcare	Skokie	Mgmt co.
A&F Partnership	35	Integrity HC of Alton	Alton			
Ted Lehrman	5	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	\$	Senior Healthcare Management		\$ 1,826	\$ 1,826	1
2	V	6 Maintenance		Senior Healthcare Management		233	233	2
3	V	19 Professional Fees	167,500	Senior Healthcare Management		261	(167,239)	3
4	V	20 Licenses & Fees		Senior Healthcare Management		79	79	4
5	V	21 Office Supplies		Senior Healthcare Management		2,631	2,631	5
6	V	21 Office Expense		Senior Healthcare Management		812	812	6
7	V	21 Payroll		Senior Healthcare Management		132,052	132,052	7
8	V	22 Employee Benefits		Senior Healthcare Management		10,226	10,226	8
9	V	24 Travel/Seminar		Senior Healthcare Management		4,142	4,142	9
10	V	26 Insurance		Senior Healthcare Management		18	18	10
11	V	34 Facility Rent		Senior Healthcare Management		7,781	7,781	11
12	V	35 Equipment Lease		Senior Healthcare Management		768	768	12
13	V							13
14	Total		\$ 167,500			\$ 160,829	\$ * (6,671)	14

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

Facility Name & ID Number

Integrity HC of Smithton

#

0053298

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 Smithton

0053298

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Integrity HC of Smithton

0053298

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			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Bank Leumi	X	Working Capital	None	5/25/15	180,000	180,000	5/25/18	5.7500	37,412										
7																				
8																				
9	TOTAL Facility Related					\$ 180,000	\$ 180,000			\$ 37,412										
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$	\$			\$										
15	TOTALS (line 9+line14)					\$ 180,000	\$ 180,000			\$ 37,412										

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.		\$	1,748	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.)		\$	35,745	2
3. Under or (over) accrual (line 2 minus line 1).		\$	33,997	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	3,248	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.		\$	37,245	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012		8
	2013		9
	2014	31,573	10
	2015	33,430	11
	2016	35,745	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,919 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1

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 an unlabeled column with values 1, 2, 3. Row 3 is shaded and labeled 'TOTALS'.

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	Door with push paddle & standard lock cylinder		2015	3,565	91	39	91		228	9
10										10
11	Becker Floor Covering - new kitchen floor		2016	4349	112	39	112		163	11
12	Marmic Fire & Safety Co. Inc. - install fire alarm+panel		2016	16318	418	39	418		610	12
13	Direct Supply, Inc. - new heater installation		2016	1508	39	39	39		57	13
14										14
15	New condensing unit		2017	2,164	28	39	28		28	15
16	Delayed egress install		2017	4,800	62	39	62		62	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

*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)	\$ 32,704	\$ 750		\$ 750	\$	\$ 1,148	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	\$ 28,885	\$ 5,777	\$ 5,777	\$	5	\$ 13,170	71
72	Current Year Purchases	30,383	3,038	3,038		5	3,038	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 59,268	\$ 8,815	\$ 8,815	\$		\$ 16,208	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)	\$ 91,972	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,565	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 9,565	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 17,356	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: 107 South Lincoln, 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>101</u>	<u>11/24/14</u>	\$ <u>209,032</u>	<u>20</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		101		\$ 209,032			7

10. Effective dates of current rental agreement:

Beginning 11/24/14

Ending 11/24/34

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2018</u>	\$ <u>210,596</u>
13.	<u>12/31/2019</u>	\$ <u>216,918</u>
14.	<u>12/31/2020</u>	\$ <u>223,422</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		<u>N/A</u>	\$ _____	\$ _____	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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	143	\$ 2,990	\$	143	\$ 2,990	1
2	Licensed Speech and Language Development Therapist		hrs		66	3,173		66	3,173	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		600	5,924		600	5,924	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				9,357		9,357	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>XRAY and LAB</u>	39-2					40		40	12
13	Other (specify): _____									13
14	TOTAL			\$	809	\$ 12,087	\$ 9,397	809	\$ 21,484	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2017**

(last day of reporting year)

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	\$ 20,087	\$ 20,087	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	868,621	868,621	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	157,880	157,880	6
7	Other Prepaid Expenses	(7,000)	(7,000)	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	128,162	128,162	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,167,750	\$ 1,167,750	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	32,704	32,704	15
16	Equipment, at Historical Cost	59,268	59,268	16
17	Accumulated Depreciation (book methods)	(17,356)	(17,356)	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)	\$ 74,616	\$ 74,616	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,242,366	\$ 1,242,366	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 444,238	\$ 444,238	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	141,570	141,570	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,830	10,830	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)	\$ 596,638	\$ 596,638	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	180,000	180,000	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)	\$ 180,000	\$ 180,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 776,638	\$ 776,638	46
47	TOTAL EQUITY(page 18, line 24)	\$ 465,726	\$ 465,728	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,242,364	\$ 1,242,366	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 388,386	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 388,386	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	77,339	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) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 77,340	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)	\$ 465,726	24 *

* This must agree with page 17, line 47.

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,589,397	1
2	Discounts and Allowances for all Levels	(27,320)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,562,077	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	27,320	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 27,320	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	235	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 235	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	945	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 945	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,590,577	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	663,542	31
32	Health Care	1,559,925	32
33	General Administration	704,513	33
B. Capital Expense			
34	Ownership	295,449	34
C. Ancillary Expense			
35	Special Cost Centers	9,397	35
36	Provider Participation Fee	234,084	36
D. Other Expenses (specify):			
37	Bad Debt	46,328	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,513,238	40
41	Income before Income Taxes (line 30 minus line 40)**	77,339	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 77,339	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,341,072	44
45	Private Pay - Net Inpatient Revenue	103,162	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)	117,843	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,562,077	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 Smithton

0053298

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	2,071	2,221	\$ 75,718	\$ 34.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,208	3,529	77,222	21.88	3
4	Licensed Practical Nurses	20,535	22,375	392,187	17.53	4
5	CNAs & Orderlies	33,615	38,020	425,807	11.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,867	4,279	48,365	11.30	9
10	Activity Assistants					10
11	Social Service Workers	8,225	9,550	122,450	12.82	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,700	15,538	152,770	9.83	15
16	Dishwashers					16
17	Maintenance Workers	1,024	1,831	23,948	13.08	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,311	1,387	48,933	35.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,062	2,368	27,526	11.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,206	2,491	27,404	11.00	31
32	Other Health C: <u>Admission Cord</u>					32
33	Other(specify) <u>MDS</u>	2,326	2,525	55,129	21.83	33
34	TOTAL (lines 1 - 33)	93,150	106,114	\$ 1,477,459 *	\$ 13.92	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	163	\$ 5,695	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	747	26,142	10-3	38
39	Pharmacist Consultant	180	8,982	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	180	6,293	12-3	45
46	Other(specify) <u>MDS Consult</u>	347	12,134	10-3	46
47	<u>HR Corporate Compliance Consultant</u>	357	17,860	21-3	47
48	<u>Marketing Consultant</u>	156	7,795	19-3	48
49	TOTAL (lines 35 - 48)	2,130	\$ 84,901		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

Facility Name & ID Number Integrity HC of Smithton

0053298

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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? NO
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. \$ 4,169 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 234,084
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation. NO
- 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? 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? N/A
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. N/A
Attach invoices and a summary of services for all architect and appraisal fees