

FOR BHF USE					

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**2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)**

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

<p>I. IDPH License ID Number: <u>0051003</u></p> <p>Facility Name: <u>INTEGRITY HC OF COBDEN</u></p> <p>Address: <u>430 South Front Street</u> <u>Cobden</u> <u>62920</u> <small>Number City Zip Code</small></p> <p>County: <u>Union City</u></p> <p>Telephone Number: <u>(708) 236-0000</u> Fax # <u>(708) 236-0001</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>06/01/10</u></p> <p>Type of Ownership:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width: 33%; border: none;"> <input checked="checked" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="checked" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width: 33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Daniel S. Gaafar</u> Telephone Number: <u>(317) 237-5500</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="checked" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="checked" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2018</u> to <u>12/31/2018</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Date) _____ (Type or Print Name) <u>Alan Irni</u> (Title) <u>CFO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Date) _____ (Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u> (Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225</u> (Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u> </td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Alan Irni</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u> (Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225</u> (Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="checked" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="checked" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Alan Irni</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u> (Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN 46225</u> (Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>							

Facility Name & ID Number INTEGRITY HC OF COBDEN

0051003 Report Period Beginning: 01/01/2018 Ending: 12/31/2018

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	2,332	176	276	2,783	8
9	SNF/PED					9
10	ICF	13,212	2,384	1,563	17,160	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,544	2,560	1,839	19,943	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.84%

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 1,387

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: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number **INTEGRITY HC OF COBDEN** # **0051003** Report Period Beginning: **01/01/2018** Ending: **12/31/2018**

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	116,758	9,150	4,372	130,280		130,280	(1,145)	129,135		1
2	Food Purchase		128,183		128,183		128,183		128,183		2
3	Housekeeping	80,097	8,484		88,581		88,581		88,581		3
4	Laundry	33,128	6,840		39,968		39,968		39,968		4
5	Heat and Other Utilities			81,059	81,059		81,059	1,192	82,251		5
6	Maintenance	39,260	12,922	15,958	68,140		68,140	201	68,341		6
7	Other (specify):*										7
8	TOTAL General Services	269,243	165,579	101,389	536,211		536,211	248	536,459		8
	B. Health Care and Programs										
9	Medical Director			10,200	10,200		10,200		10,200		9
10	Nursing and Medical Records	764,063	58,585	35,388	858,036		858,036		858,036		10
10a	Therapy			316,956	316,956		316,956		316,956		10a
11	Activities	30,815	4,459		35,274		35,274		35,274		11
12	Social Services	43,170		5,332	48,502		48,502		48,502		12
13	CNA Training										13
14	Program Transportation			16	16		16		16		14
15	Other (specify):* Pharmacy Consult			6,012	6,012		6,012		6,012		15
16	TOTAL Health Care and Programs	838,048	63,044	373,904	1,274,996		1,274,996		1,274,996		16
	C. General Administration										
17	Administrative	84,700			84,700		84,700		84,700		17
18	Directors Fees										18
19	Professional Services			197,547	197,547		197,547	(190,950)	6,597		19
20	Dues, Fees, Subscriptions & Promotions			11,109	11,109		11,109	18	11,127		20
21	Clerical & General Office Expenses	41,639	19,393	51,439	112,471		112,471	139,518	251,989		21
22	Employee Benefits & Payroll Taxes			132,438	132,438		132,438	11,801	144,239		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,899	4,899		4,899	4,800	9,699		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			126,000	126,000		126,000	441	126,441		26
27	Other (specify):*										27
28	TOTAL General Administration	126,339	19,393	523,432	669,164		669,164	(34,372)	634,792		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,233,630	248,016	998,725	2,480,371		2,480,371	(34,124)	2,446,247		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			15,646	15,646		15,646		15,646			30
31	Amortization of Pre-Op. & Org.			815	815		815		815			31
32	Interest			71,358	71,358		71,358	(14)	71,344			32
33	Real Estate Taxes			23,540	23,540		23,540		23,540			33
34	Rent-Facility & Grounds			231,373	231,373		231,373	9,470	240,843			34
35	Rent-Equipment & Vehicles							1,053	1,053			35
36	Other (specify):* Replacement Tax			263	263		263	(263)				36
37	TOTAL Ownership			342,995	342,995		342,995	10,246	353,241			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,503		81,503		81,503		81,503			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			155,333	155,333		155,333		155,333			42
43	Other (specify):*			21,962	21,962		21,962	(21,962)				43
44	TOTAL Special Cost Centers		81,503	177,295	258,798		258,798	(21,962)	236,836			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,233,630	329,519	1,519,015	3,082,164		3,082,164	(45,840)	3,036,324			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				9
10	Interest and Other Investment Income	(14)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,145)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(21,962)	43		24
25	Fund Raising, Advertising and Promotional	(10,031)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(263)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (33,415)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	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)	(12,425)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,425)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (45,840)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44						44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

INTEGRITY HC OF COBDEN

ID# 0051003

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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
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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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number INTEGRITY HC OF COBDEN

0051003

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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	(1,145)	0	0	0	0	0	0	0	0	0	0	(1,145)	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	1,192	0	0	0	0	0	0	0	0	0	1,192	5
6	Maintenance	0	201	0	0	0	0	0	0	0	0	0	201	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,145)	1,393	0	0	0	0	0	0	0	0	0	248	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	(190,950)	0	0	0	0	0	0	0	0	0	(190,950)	19
20	Fees, Subscriptions & Promotions	0	18	0	0	0	0	0	0	0	0	0	18	20
21	Clerical & General Office Expenses	(10,031)	149,549	0	0	0	0	0	0	0	0	0	139,518	21
22	Employee Benefits & Payroll Taxes	0	11,801	0	0	0	0	0	0	0	0	0	11,801	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	4,800	0	0	0	0	0	0	0	0	0	4,800	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	441	0	0	0	0	0	0	0	0	0	441	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(10,031)	(24,341)	0	0	0	0	0	0	0	0	0	(34,372)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(11,176)	(22,948)	0	0	0	0	0	0	0	0	0	(34,124)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number INTEGRITY HC OF COBDEN# 0051003

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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	(14)	0	0	0	0	0	0	0	0	0	0	(14)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	9,470	0	0	0	0	0	0	0	0	0	9,470	34
35	Rent-Equipment & Vehicles	0	1,053	0	0	0	0	0	0	0	0	0	1,053	35
36	Other (specify):*	(263)	0	0	0	0	0	0	0	0	0	0	(263)	36
37	TOTAL Ownership	(277)	10,523	0	0	0	0	0	0	0	0	0	10,246	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):*	(21,962)	0	0	0	0	0	0	0	0	0	0	(21,962)	43
44	TOTAL Special Cost Centers	(21,962)	0	0	0	0	0	0	0	0	0	0	(21,962)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(33,415)	(12,425)	0	0	0	0	0	0	0	0	0	(45,840)	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 %	See attached		Senior Healthcare	Skokie	Management Co.
A7F general Partnership	35 %					
Ted Lerman	5 %					

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		\$ 1,192	\$ 1,192	1
2	V	6 Repairs		Senior Healthcare Management		201	201	2
3	V	19 Professional Services	192,000	Senior Healthcare Management		1,050	(190,950)	3
4	V	20 Licenses & Fees		Senior Healthcare Management		18	18	4
5	V	21 Office Supplies		Senior Healthcare Management		149,549	149,549	5
6	V	22 Employee Benefits		Senior Healthcare Management		11,801	11,801	6
7	V	24 Travel / Seminar		Senior Healthcare Management		4,800	4,800	7
8	V	26 Insurance		Senior Healthcare Management		441	441	8
9	V	34 Rent Expense		Senior Healthcare Management		9,470	9,470	9
10	V	35 Equipment Lease		Senior Healthcare Management		1,053	1,053	10
11	V							11
12	V							12
13	V							13
14	Total		\$ 192,000			\$ 179,575	\$ * (12,425)	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:

01/01/2018

Ending:

12/31/2018

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 Alton	Alton				1
2			Integrity HC of Anna	Anna				2
3			Integrity HC of Carbondale	Carbondale				3
4			Integrity HC of Columbia	Columbia				4
5			Integrity HC of Herrin	Herrin				5
6			Integrity HC of Marion	Marion				6
7			Integrity HC of Belleville	Belleville				7
8			Integrity HC of Smithton	Smithton				8
9			Integrity HC of Wood River	Wood River				9
10			Integrity HC of Godfrey	Godfrey				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: 01/01/2018 Ending: 12/31/2018

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:

01/01/2018

Ending: 2/31/2018

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 COBDEN

0051003

Report Period Beginning:

01/01/2018

Ending:

12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
2																				
3																				
4																				
5																				
Working Capital																				
6	Bank Leumi	X	WORKING CAPITAL	NONE	3/6/18	4,500,000	310,000	3/31/19	6.7500	71,358										
7																				
8																				
9	TOTAL Facility Related					\$ 4,500,000	\$ 310,000			\$ 71,358										
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$	\$			\$										
15	TOTALS (line 9+line14)					\$ 4,500,000	\$ 310,000			\$ 71,358										

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 2017 report.		\$	47,190	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.)		\$	21,844	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(25,346)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	48,886	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.		\$	23,540	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	21,111	8	
	2014	21,542	9	
	2015	21,400	10	
	2016	21,558	11	
	2017	21,844	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME INTEGRITY HC OF COBDEN COUNTY Union City

FACILITY IDPH LICENSE NUMBER 0051003

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>04-31-02-784-C</u>	<u>LONG TERM CARE PROPERTY</u>	\$ <u>21,844.00</u>	\$ <u>21,844.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>21,844.00</u></u>	\$ <u><u>21,844.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ 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).

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
	Improvement Type**									
9	Fire Panels		2011	7,852	201	39	201		1,457	9
10	Sprinklers		2011	154,499	3,962	39	3,962		29,055	10
11	Guard Rails		2011	18,200	467	39	467		3,425	11
12	Roof Repairs		2012	61,000	1,564	39	1,564		10,883	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		23,572	15
16	Wiring nurse stations and kiosks		2013	11,039	283	39	283		1,509	16
17										17
18	Labor to install alarm system		2015	986	25	39	25		87	18
19	Installation of alarm system		2015	1,003	26	39	26		90	19
20	1,596 sq yrds of hot-mix asphalt		2015	23,394	600	39	600		2,074	20
21	Install safety glass windows to doors		2015	850	22	39	22		76	21
22	260 ft of pvc / vinyl fence and 3 gates		2015	12,522	321	39	321		1,110	22
23	Door with hinges, closer, panic exit		2015	3,880	99	39	99		343	23
24										24
25	Compressor		2016	2,171	56	39	56		144	25
26	Exhaust Fan		2016	1,527	39	39	39		94	26
27	Utility Room water leak repair		2016	1,485	38	39	38		89	27
28										28
29	Laundry unit system		2017	3,633	93	39	93		140	29
30										30
31	Water Mitigation - repair broken water line in ceiling		2018	4,656	60	39	60	(0)	60	31
32	Lifeproof multi-width flooring replacement		2018	1,299	16	39	16		16	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)	\$ 465,364	\$ 11,856		\$ 11,856	\$ (0)	\$ 74,224	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	\$ 19,671	\$ 3,127	\$ 3,127	\$	5	\$ 13,121	71
72	Current Year Purchases	6,625	663	663		5	663	72
73	Fully Depreciated Assets	14,273					14,273	73
74								74
75	TOTALS	\$ 40,569	\$ 3,790	\$ 3,790	\$		\$ 28,057	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)	\$ 505,933	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,646	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,646	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 102,281	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: 01/01/2018

Ending: 12/31/2018

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:	<u>1995</u>	<u>74</u>	<u>10/1/15</u>	\$ <u>231,373</u>	<u>20</u>	<u>N/A</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>74</u>		\$ <u>231,373</u>			7

10. Effective dates of current rental agreement:

Beginning 10/01/15

Ending 09/30/25

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

Fiscal Year Ending Annual Rent

12.	<u>12/2019</u>	\$ <u>836,271</u>
13.	<u>12/2020</u>	\$ <u>861,359</u>
14.	<u>12/2021</u>	\$ <u>887,200</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A

N/A

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ N/A Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			\$ _____	\$ _____	18
19			\$ _____	\$ _____	19
20			\$ _____	\$ _____	20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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	10a-3	hrs	\$	1,957	\$ 125,871	\$	1,957	\$ 125,871	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		729	53,911		729	53,911	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		3,066	137,174		3,066	137,174	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				73,601		73,601	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Radiology & Lab</u>	39 - 2					7,902		7,902	12
13	Other (specify):									13
14	TOTAL			\$	5,752	\$ 316,956	\$ 81,503	5,752	\$ 398,459	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 **12/31/2018**

(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	\$ (44,158)	\$ (44,158)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,782,575	1,782,575	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,974	34,974	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,773,391	\$ 1,773,391	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	465,363	465,363	15
16	Equipment, at Historical Cost	40,568	40,568	16
17	Accumulated Depreciation (book methods)	(102,281)	(102,281)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,995)	(6,995)	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)	\$ 408,880	\$ 408,880	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,182,271	\$ 2,182,271	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 524,684	\$ 524,684	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,518	118,518	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,067	9,067	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)	\$ 652,269	\$ 652,269	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	310,000	310,000	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)	\$ 310,000	\$ 310,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 962,269	\$ 962,269	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,220,002	\$ 1,220,002	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,182,271	\$ 2,182,271	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,093,244	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,093,244	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	126,758	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 126,758	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)	\$ 1,220,002	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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,017,906	1
2	Discounts and Allowances for all Levels	(47,791)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,970,115	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	238,793	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 238,793	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***	14	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,208,922	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	536,211	31
32	Health Care	1,274,996	32
33	General Administration	669,164	33
B. Capital Expense			
34	Ownership	342,995	34
C. Ancillary Expense			
35	Special Cost Centers	81,503	35
36	Provider Participation Fee	155,333	36
D. Other Expenses (specify):			
37	<u>Bad Debt</u>	21,962	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,082,164	40
41	Income before Income Taxes (line 30 minus line 40)**	126,758	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 126,758	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,872,335	44
45	Private Pay - Net Inpatient Revenue	146,625	45
46	Medicare - Net Inpatient Revenue	649,652	46
47	Other-(specify)	301,503	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,970,115	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No-cash basis 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 COBDEN

0051003

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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	1,629	1,750	\$ 53,196	\$ 30.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,800	5,164	133,124	25.78	3
4	Licensed Practical Nurses	7,197	7,645	163,280	21.36	4
5	CNAs & Orderlies	27,114	28,823	371,173	12.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,020	3,160	30,815	9.75	10
11	Social Service Workers	3,304	3,598	43,170	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,294	12,094	116,758	9.65	15
16	Dishwashers					16
17	Maintenance Workers	1,851	1,972	39,260	19.91	17
18	Housekeepers	8,564	8,946	80,097	8.95	18
19	Laundry	3,568	3,824	33,128	8.66	19
20	Administrator	2,428	2,562	84,700	33.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	990	990	11,692	11.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,766	1,873	29,947	15.99	32
33	Other(specify) <u>MDS</u>	1,914	2,022	43,290	21.41	33
34	TOTAL (lines 1 - 33)	78,439	84,423	\$ 1,233,630 *	\$ 14.61	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	92	\$ 4,372	1 - 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	565	19,765	10 - 3	38
39	Pharmacist Consultant	120	6,012	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	97	5,332	12 - 3	45
46	Other(specify) <u>MDS</u>	446	15,623	10 - 3	46
47	<u>HR Corp Compliance</u>	328	16,403	21 - 3	47
48	<u>Marketing Consultant</u>	154	7,709	21 - 3	48
49	TOTAL (lines 35 - 48)	1,803	\$ 75,216		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Yates Gayle	Administrator	0	\$ 21,549	Workers' Compensation Insurance	\$ 30,440	IDPH License Fee	\$ 5,814	
Parmly-Simmons Baleigh J	Administrator	0	18,015	Unemployment Compensation Insurance	(2,024)	Advertising: Employee Recruitment		
Middleton Susan	Administrator	0	15,263	FICA Taxes	89,156	Health Care Worker Background Check		
Belcher, Sherry L	Administrator	0	29,873	Employee Health Insurance	23,404	(Indicate # of checks performed _____)		
				Employee Meals		Food Sanitation Permit	400	
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council of LT Care	4,200	
				Employee Expenses	3,263	Senior Management	18	
						Secretary of State	75	
TOTAL (agree to Schedule V, line 17, col. 1)						Southern Seven Health	280	
(List each licensed administrator separately.)			\$ 84,700			Union County Chamber	340	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
			\$			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 144,239	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,127	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Sandberg Phoenix	Collections		\$ 197			\$	Out-of-State Travel	\$
Bradley Associates	Accounting Fees		900					
Polsinelli	Legal Fees		818					
Senior Management	Mgmt / Professional Fees		192,000				In-State Travel	
Johnson, Goldberg & Brown	Accounting Fees		3,000				Auto Allowance	7,852
Bank Leumi	Legal Fees		632				Mileage	1,847
							Mgmt Lodging and Fuel	
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 197,547	TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 9,699

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number INTEGRITY HC OF COBDEN

0051003

Report Period Beginning: 01/01/2018

Ending: 12/31/2018

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 - \$4200
- (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. \$ 14,763 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. \$ 155,333
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