

		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>0053306</u></p> <p>Facility Name: <u>INTEGRITY HC OF GODFREY</u></p> <p>Address: <u>1623 WEST DELMER AVE</u> <u>GODFREY</u> <u>62035</u> Number City Zip Code</p> <p>County: <u>MADISON</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>11/24/14</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></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 checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<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>01/01/18</u> to <u>12/31/18</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"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ALAN IRNI</u> (Date) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Title) <u>CFO</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>DANIEL S. GAAFAR</u> <u>PARTNER</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>BRADLEY ASSOCIATES</u> <u>201 S. Capitol Ave., Ste 700, Indianapolis, IN 46225</u></td> </tr> <tr> <td></td> <td>(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) _____	(Type or Print Name) <u>ALAN IRNI</u> (Date) _____	Paid Preparer	(Title) <u>CFO</u>	(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., Ste 700, Indianapolis, IN 46225</u>		(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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Facility Name & ID Number INTEGRITY HC OF GODFREY

0053306 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	68	Skilled (SNF)	68	24,820	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,820	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	13,007	2,328	1,405	16,740	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,007	2,328	1,405	16,740	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.45%

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)
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 68 and days of care provided 1,370

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 GODFREY** # **0053306** Report Period Beginning: **01/01/18** Ending: **12/31/18**

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	138,154	13,507	4,585	156,246		156,246		156,246		1
2	Food Purchase		107,257		107,257		107,257		107,257		2
3	Housekeeping	92,444	6,256		98,700		98,700		98,700		3
4	Laundry	26,478	5,510		31,988		31,988		31,988		4
5	Heat and Other Utilities			94,596	94,596		94,596	1,192	95,788		5
6	Maintenance	32,516	14,939	36,314	83,769		83,769	201	83,970		6
7	Other (specify):*										7
8	TOTAL General Services	289,592	147,469	135,495	572,556		572,556	1,393	573,949		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,026,162	57,501	35,389	1,119,052		1,119,052	(805)	1,118,247		10
10a	Therapy			326,628	326,628		326,628		326,628		10a
11	Activities	54,835	4,117		58,952		58,952		58,952		11
12	Social Services	27,410		4,772	32,182		32,182		32,182		12
13	CNA Training			988	988		988		988		13
14	Program Transportation			79	79		79		79		14
15	Other (specify):* Pharmacy Consult			4,914	4,914		4,914		4,914		15
16	TOTAL Health Care and Programs	1,108,407	61,618	396,770	1,566,795		1,566,795	(805)	1,565,990		16
	C. General Administration										
17	Administrative	72,376			72,376		72,376		72,376		17
18	Directors Fees										18
19	Professional Services			207,557	207,557		207,557	(190,950)	16,607		19
20	Dues, Fees, Subscriptions & Promotions			6,948	6,948		6,948	18	6,966		20
21	Clerical & General Office Expenses	55,402	21,740	58,810	135,952		135,952	131,084	267,036		21
22	Employee Benefits & Payroll Taxes			221,959	221,959		221,959	11,801	233,760		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,373	2,373		2,373	4,800	7,173		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			99,750	99,750		99,750	441	100,191		26
27	Other (specify):*										27
28	TOTAL General Administration	127,778	21,740	597,397	746,915		746,915	(42,806)	704,109		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,525,777	230,827	1,129,662	2,886,266		2,886,266	(42,218)	2,844,048		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			16,040	16,040		16,040		16,040			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,607	59,607		59,607	(546)	59,061			32
33	Real Estate Taxes			30,120	30,120		30,120		30,120			33
34	Rent-Facility & Grounds			233,388	233,388		233,388	9,470	242,858			34
35	Rent-Equipment & Vehicles							1,053	1,053			35
36	Other (specify):* Replacement Tax			6,624	6,624		6,624	(6,624)				36
37	TOTAL Ownership			345,779	345,779		345,779	3,353	349,132			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,974		65,974		65,974		65,974			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,712	130,712		130,712		130,712			42
43	Other (specify):* Bad Debt			99,796	99,796		99,796	(99,796)				43
44	TOTAL Special Cost Centers		65,974	230,508	296,482		296,482	(99,796)	196,686			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,525,777	296,801	1,705,949	3,528,527		3,528,527	(138,661)	3,389,866			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	(546)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(805)	10		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	(9,899)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(99,796)	43		24
25	Fund Raising, Advertising and Promotional	(8,407)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,624)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(159)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (126,236)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(12,425)	Various	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))	\$ (138,661)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

ID# 0053306

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Income	\$ (159)	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	(159)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number INTEGRITY HC OF GODFREY

0053306

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	1,393	0	0	0	0	0	0	0	0	0	1,393	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	(805)	0	0	0	0	0	0	0	0	0	0	(805)	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	(805)	0	0	0	0	0	0	0	0	0	0	(805)	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	(18,465)	149,549	0	0	0	0	0	0	0	0	0	131,084	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	(18,465)	(24,341)	0	0	0	0	0	0	0	0	0	(42,806)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,270)	(22,948)	0	0	0	0	0	0	0	0	0	(42,218)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

INTEGRITY HC OF GODFREY

0053306

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	(546)	0	0	0	0	0	0	0	0	0	0	(546)	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):*	(6,624)	0	0	0	0	0	0	0	0	0	0	(6,624)	36
37	TOTAL Ownership	(7,170)	10,523	0	0	0	0	0	0	0	0	0	3,353	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):*	(99,796)	0	0	0	0	0	0	0	0	0	0	(99,796)	43
44	TOTAL Special Cost Centers	(99,796)	0	0	0	0	0	0	0	0	0	0	(99,796)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(126,236)	(12,425)	0	0	0	0	0	0	0	0	0	(138,661)	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.
A&F Partnership	35%					
Ted Lehrman	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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			Senior Healthcare Management				11
12	V			Senior Healthcare Management				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 GODFREY

0053306

Report Period Beginning:

01/01/18

Ending:

12/31/18

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 Cobden	Cobden				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 Alton	Alton				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 GODFREY # 0053306 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 GODFREY

0053306

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 GODFREY

0053306

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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							\$	\$			\$	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6	Bank Leumi		x	Working Capital	Various	03/25/18	2,500,000	180,000	03/31/19	6.7500	59,607	6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 2,500,000	\$ 180,000			\$ 59,607	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 2,500,000	\$ 180,000			\$ 59,607	15						

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.	\$	4,599	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.)	\$	32,603	2
3. Under or (over) accrual (line 2 minus line 1).	\$	28,004	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	2,116	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.	\$	30,120	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2013		8
	2014	30,363	9
	2015	30,903	10
	2016	31,671	11
	2017	32,603	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 GODFREY COUNTY MADISON

FACILITY IDPH LICENSE NUMBER 0053306

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>24-2-01-33-02-204-038</u>	<u>Long Term Care Property</u>	\$ <u>32,603.00</u>	\$ <u>32,603.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>32,603.00</u></u>	\$ <u><u>32,603.00</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: 21,330 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: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 1: Use, Square Feet, Year Acquired, Cost, 1. Row 2: Use, Square Feet, Year Acquired, Cost, 2. Row 3: TOTALS, Square Feet, Year Acquired, Cost, 3.

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	New roof		2015	34,597	887	39	887		3,103	9
10	Signage		2015	2,625	67	39	67		217	10
11	Kitchen exhaust fan		2015	4,048	104	39	104		338	11
12										12
13	Replace front doors of facility		2016	6,232	160	39	160		393	13
14	Fix water damage to main level crawl space		2016	4,236	109	39	109		268	14
15	Install new lockson new front doors		2016	2,609	67	39	67		165	15
16	Replace 25 ' of sewer pipe in basement		2016	2,840	73	39	73		179	16
17	New fire alarm installed		2016	16,857	432	39	432		1,062	17
18										18
19	Electrical and lighting work and wallcovering in main lobby									19
20	and prep walls, winstall wallcovering, paint ceiling beams,									20
21	pipes, wire covers, doorframes and shopfront		2017	46,821	1,200	39	1,200		1,800	21
22	New water heater		2017	3,515	90	39	90		135	22
23										23
24	Wiring for wireless connection for PCC		2018	1,160	15	39	15		15	24
25	Installation of 11 new skylights		2018	9,942	127	39	127		127	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

Facility Name & ID Number INTEGRITY HC OF GODFREY

0053306

Report Period Beginning:

01/01/18

Ending:

12/31/18

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)	\$ 135,482	\$ 3,331		\$ 3,331	\$	\$ 7,802	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	\$ 48,769	\$ 9,754	\$ 9,754	\$		\$ 26,091	71
72	Current Year Purchases	29,547	2,955	2,955			2,955	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 78,316	\$ 12,709	\$ 12,709	\$		\$ 29,046	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)	\$ 213,798	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,040	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,040	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)	\$ 36,848	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: 1623 West Delmar Avenue 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:		68	11/24/14	\$ 233,388	20	10	3
4	Additions							4
5								5
6								6
7	TOTAL		68		\$ 233,388			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>12/31/2019</u>	\$ <u>237,666</u>
13.	<u>12/31/2020</u>	\$ <u>240,238</u>
14.	<u>12/31/2021</u>	\$ <u>242,640</u>

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17		<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 checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>HOURS PER CNA <u>6</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" 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	\$	\$ 988	\$	\$ 988
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	\$	\$ 988	\$	\$ 988
10	SUM OF line 9, col. 1 and 2 (e)	\$	988		

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

- (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	\$	2,100	\$ 142,457	\$	2,100	\$ 142,457	1
2	Licensed Speech and Language Development Therapist	10a - 3	hrs		1,386	53,475		1,386	53,475	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a - 3	hrs		1,996	130,696		1,996	130,696	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				59,065		59,065	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____	39 - 2					6,909		6,909	12
13	Other (specify): _____									13
14	TOTAL			\$	5,482	\$ 326,628	\$ 65,974	5,482	\$ 392,602	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 **12/31/18**

(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	\$ (50,866)	\$ (50,866)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	860,114	860,114	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,523	3,523	6
7	Other Prepaid Expenses	76,503	76,503	7
8	Accounts Receivable (owners or related parties)	687,172	687,172	8
9	Other(specify): Replacement Reserve	210,030	210,030	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,786,476	\$ 1,786,476	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	135,482	135,482	15
16	Equipment, at Historical Cost	78,316	78,316	16
17	Accumulated Depreciation (book methods)	(36,849)	(36,849)	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)	\$ 176,949	\$ 176,949	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,963,425	\$ 1,963,425	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 544,014	\$ 544,014	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(2,292)	(2,292)	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	148,370	148,370	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,350	11,350	31
32	Accrued Real Estate Taxes(Sch.IX-B)			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)	\$ 701,442	\$ 701,442	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)	\$ 881,442	\$ 881,442	46
47	TOTAL EQUITY(page 18, line 24)	\$ 881,983	\$ 881,983	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,763,425	\$ 1,763,425	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,148,743	1
2	Restatements (describe):		2
3	Prior year adjustment	(50,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,098,743	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(66,760)	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	(150,000)	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)	\$ (216,760)	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)	\$ 881,983	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number INTEGRITY HC OF GODFREY

0053306

Report Period Beginning: 01/01/18

Ending: 12/31/18

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	\$ 3,237,553	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,237,553	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	223,508	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 223,508	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***	546	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 546	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	159	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 159	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,461,766	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	572,556	31
32	Health Care	1,565,806	32
33	General Administration	747,903	33
B. Capital Expense			
34	Ownership	345,779	34
C. Ancillary Expense			
35	Special Cost Centers	65,974	35
36	Provider Participation Fee	130,712	36
D. Other Expenses (specify):			
37	<u>Bad debt</u>	99,796	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,528,526	40
41	Income before Income Taxes (line 30 minus line 40)**	(66,760)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (66,760)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,143,142	44
45	Private Pay - Net Inpatient Revenue	412,245	45
46	Medicare - Net Inpatient Revenue	664,734	46
47	Other-(specify)	17,433	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,237,554	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 GODFREY

0053306

Report Period Beginning: 01/01/18

Ending: 12/31/18

12/31/18

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	1,732	1,853	\$ 67,902	\$ 36.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,719	4,151	131,606	31.70	3
4	Licensed Practical Nurses	13,681	14,368	366,015	25.47	4
5	CNAs & Orderlies	29,902	31,632	403,511	12.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,158	4,479	54,835	12.24	10
11	Social Service Workers	1,339	1,457	27,410	18.81	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,224	13,024	138,154	10.61	15
16	Dishwashers					16
17	Maintenance Workers	1,950	2,081	32,516	15.63	17
18	Housekeepers	6,524	7,047	92,444	13.12	18
19	Laundry	1,824	1,988	26,478	13.32	19
20	Administrator	1,940	2,061	72,376	35.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,975	2,098	55,401	26.41	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	2,001	2,131	29,741	13.96	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS</u>	836	981	27,388	27.92	33
34	TOTAL (lines 1 - 33)	83,805	89,351	\$ 1,525,777 *	\$ 17.08	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	97	\$ 4,585	1 - 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	565	19,765	10 - 3	38
39	Pharmacist Consultant	98	4,914	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	87	4,772	12 - 3	45
46	Other(specify) <u>MDS Consultant</u>	446	15,623	10 - 3	46
47	<u>HR Corp Compliance</u>	328	16,403	12 - 3	47
48	<u>Marketing Consultant</u>	109	5,459	21 - 3	48
49	TOTAL (lines 35 - 48)	1,730	\$ 71,521		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	
Varwig, Barbara	Administrator	0	\$ 36,619	Workers' Compensation Insurance	\$ 41,293	IDPH License Fee	\$ 1,990	
Ritchie, Kyle M.	Administrator	0	35,757	Unemployment Compensation Insurance	18,438	Advertising: Employee Recruitment		
				FICA Taxes	102,727	Health Care Worker Background Check		
				Employee Health Insurance	56,431	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on LTC	4,200	
				Employee Expense	3,071	Clia Laboratory	150	
						Madison County Health Dept	375	
TOTAL (agree to Schedule V, line 17, col. 1)						Various	233	
(List each licensed administrator separately.)			\$ 72,376					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ 221,960	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,948	
			\$			Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount				\$		
Sanberg Phoenix	Collection Fees	\$ 10,839					Out-of-State Travel	\$
Bradley Associates	Accounting Fees	900						
Johnson, Goldberg & Brown	Accounting Fees	3,000						
Senior Management	Management Fees	192,000					In-State Travel	
Polsinelli	Legal Fees	818					Auto Allowance	917
							Mileage	1,456
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 207,557	TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2,373

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ILLINOIS COUNCIL - \$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. \$ 13,675 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.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 130,712
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 benefit 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.
 - 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? 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