		FOR BHF USE					

LL1

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.

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

I. IDPH License ID Number: 0053298

Facility Name: INTEGRITY HC OF SMITHTON

Address: 107 SOUTH LINCOLN (Number) SMITHTON (City) 62285 (Zip Code)

County: ST. CLAIR

Telephone Number: (708) 236-0000 **Fax #** (708) 236-0001

HFS ID Number:

Date of Initial License for Current Owners: 11/24/14

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] VOLUNTARY,NON-PROFIT	[X] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code ____	[ ] Corporation	[ ] Other ____
	[ ] "Sub-S" Corp.	
	[X] Limited Liability Co.	
	[ ] Trust	
	[ ] Other ____	

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	ALAN IRNI
	(Title)	CFO
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	DANIEL S. GAAFAR PARTNER
	(Firm Name & Address)	BRADLEY ASSOCIATES 201 S. Capitol Ave., Ste 700, Indianapolis, IN 46225
	(Telephone)	(317) 237-5500 Fax # (317) 237-5503

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

In the event there are further questions about this report, please contact:
Name: DANIEL S. GAAFAR Telephone Number: (317) 237-5500
Email Address:

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	101	Intermediate (ICF)	101	36,865	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	20,152	1,569	365	22,086	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,152	1,569	365	22,086	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.91%

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 [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

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 [x] Date 11/24/14 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] 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 SMITHTON # 0053298 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	148,646	10,354	6,298	165,298		165,298		165,298			1
2	Food Purchase		137,486		137,486		137,486		137,486			2
3	Housekeeping	88,115	1,312		89,427		89,427		89,427			3
4	Laundry	57,305	5,051		62,356		62,356		62,356			4
5	Heat and Other Utilities			110,162	110,162		110,162	1,192	111,354			5
6	Maintenance	12,953	13,901	25,406	52,260		52,260	201	52,461			6
7	Other (specify):*											7
8	**TOTAL General Services**	307,019	168,104	141,866	616,989		616,989	1,393	618,382			8
	B. Health Care and Programs											
9	Medical Director			17,750	17,750		17,750		17,750			9
10	Nursing and Medical Records	1,044,663	35,274	35,389	1,115,326		1,115,326	(258)	1,115,068			10
10a	Therapy			9,597	9,597		9,597		9,597			10a
11	Activities	50,504	3,788		54,292		54,292		54,292			11
12	Social Services	84,455		6,377	90,832		90,832		90,832			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			6,093	6,093		6,093		6,093			15
16	**TOTAL Health Care and Programs**	1,179,622	39,062	75,206	1,293,890		1,293,890	(258)	1,293,632			16
	C. General Administration											
17	Administrative	50,415			50,415		50,415		50,415			17
18	Directors Fees											18
19	Professional Services			199,227	199,227		199,227	(190,950)	8,277			19
20	Dues, Fees, Subscriptions & Promotions			10,116	10,116		10,116	18	10,134			20
21	Clerical & General Office Expenses	27,956	27,874	62,996	118,826		118,826	140,898	259,724			21
22	Employee Benefits & Payroll Taxes			208,240	208,240		208,240	11,801	220,041			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,653	2,653		2,653	4,800	7,453			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			171,000	171,000		171,000	441	171,441			26
27	Other (specify):*											27
28	**TOTAL General Administration**	78,371	27,874	654,232	760,477		760,477	(32,992)	727,485			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,565,012	235,040	871,304	2,671,356		2,671,356	(31,857)	2,639,499			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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,847	13,847		13,847		13,847			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			59,607	59,607		59,607		59,607			32
33	Real Estate Taxes			40,603	40,603		40,603		40,603			33
34	Rent-Facility & Grounds			209,032	209,032		209,032	9,470	218,502			34
35	Rent-Equipment & Vehicles							1,053	1,053			35
36	Other (specify):* Replacement Tax			2,341	2,341		2,341	(2,341)				36
37	TOTAL Ownership			325,430	325,430		325,430	8,182	333,612			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		5,649		5,649		5,649		5,649			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			178,904	178,904		178,904		178,904			42
43	Other (specify):* Bad Debt			69,688	69,688		69,688	(69,688)				43
44	TOTAL Special Cost Centers		5,649	248,592	254,241		254,241	(69,688)	184,553			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,565,012	240,689	1,445,326	3,251,027		3,251,027	(93,363)	3,157,664			45

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

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(258)	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				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	(69,688)	43		24
25	Fund Raising, Advertising and Promotional	(8,126)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,341)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(525)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (80,938)		$	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 Amount	2 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
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (93,363)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

INTEGRITY HC OF SMITHTON

ID# 0053298

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (525)	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	(525)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	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	(258)	0	0	0	0	0	0	0	0	0	0	(258)	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**	(258)	0	0	0	0	0	0	0	0	0	0	(258)	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	(8,651)	149,549	0	0	0	0	0	0	0	0	0	140,898	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**	(8,651)	(24,341)	0	0	0	0	0	0	0	0	0	(32,992)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,909)	(22,948)	0	0	0	0	0	0	0	0	0	(31,857)	29

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 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 D. Ownership	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)	
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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	(2,341)	0	0	0	0	0	0	0	0	0	0	(2,341)	36
37	**TOTAL Ownership**	(2,341)	10,523	0	0	0	0	0	0	0	0	0	8,182	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):*	(69,688)	0	0	0	0	0	0	0	0	0	0	(69,688)	43
44	**TOTAL Special Cost Centers**	(69,688)	0	0	0	0	0	0	0	0	0	0	(69,688)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(80,938)	(12,425)	0	0	0	0	0	0	0	0	0	(93,363)	45

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

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. [x] 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	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: 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				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 SMITHTON # 0053298 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 Alton	Alton				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 SMITHTON # 0053298 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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	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								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 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 [x]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 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	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							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		x	Working Capital	None	05/25/18	2,500,000	210,000	03/31/19	6.7500	27,221	6
7	LTC Funding	x		Working Capital	None	Various	7,210,000		Various	Various	32,386	7
8												8
9	TOTAL Facility Related						$ 9,710,000	$ 210,000			$ 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)						$ 9,710,000	$ 210,000			$ 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.)

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2017 report.	$	3,248	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.)	$	44,975	2
3. Under or (over) accrual (line 2 minus line 1).	$	41,727	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	(1,124)	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.	$	40,603	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2013		8
2014	31,573	9
2015	33,430	10
2016	35,745	11
2017	44,975	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 SMITHTON COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0053298

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)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	13-33.0-113-004	Long Term Nursing Home	$ 44,975.24	$ 44,975.24
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 44,975.24	$ 44,975.24

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.

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (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? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (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 [x] 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.

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

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door with push paddle & standard lock cylinder			2015	3,565	91	39	91		319	9
10											10
11	Becker Floor Covering - new kitchen floor			2016	4,349	112	39	112		275	11
12	Marmic Fire & Safety Co. Inc. - install fire alarm and panel			2016	16,318	418	39	418		1,028	12
13	Direct Supply, Inc. - new heater installation			2016	1,508	39	39	39		96	13
14											14
15	New condensing unit			2017	2,164	56	39	56		84	15
16	Delayed egress install			2017	4,800	123	39	123		184	16
17											17
18	Murals in Large cafeteria, TV room and Large hall			2018	38,420	493	39	493		493	18
19	Wiring for Mesh A60 PCC			2018	1,160	15	39	15		15	19
20	Replacement of micro switch on front door crash bar			2018	3,841	49	39	49		49	20
21	Furnish and install conduit and wire to restore power to rooms										21
22	312, 314, 315 and 317			2018	6,995	90	39	90		90	22
23	Removal and replacement of existing water heater			2018	1,550	20	39	20		20	23
24	Repair dining room ceiling			2018	1,750	22	39	22		22	24
25	Wall A/C unit replacement			2018	759	10	39	10		10	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 SMITHTON # 0053298 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 87,179	$ 1,538		$ 1,538	$	$ 2,685	70

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

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 59,268	$ 11,854	$ 11,854	$	5	$ 28,063	71
72	Current Year Purchases	4,645	465	465			465	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 63,913	$ 12,319	$ 12,319	$		$ 28,528	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)	$ 151,092	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 13,857	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,857	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)	$ 31,213	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 SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 107 South Lincoln, LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [x] 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:		101	11/24/14	$ 209,032	20	10	3
4	Additions							4
5								5
6								6
7	TOTAL		101		$ 209,032 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: *

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.	12/31/2019	$ 212,864
13.	12/31/2020	$ 215,167
14.	12/31/2021	$ 217,319

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ N/A Description: N/A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A - 3	hrs	$	145	$ 3,044	$	145	$ 3,044	1
2	Licensed Speech and Language Development Therapist	10A - 3	hrs		19	910		19	910	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A - 3	hrs		269	5,643		269	5,643	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 prescrpts				5,639		5,639	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): XRAY AND LAB	39 - 2					10		10	12
13	Other (specify):									13
14	TOTAL			$	433	$ 9,597	$ 5,649	433	$ 15,246	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.

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (11,894)	$ (11,894)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	223,587	223,587	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,220	2,220	6
7	Other Prepaid Expenses	44,322	44,322	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	415,099	415,099	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 673,334	$ 673,334	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	87,179	87,179	15
16	Equipment, at Historical Cost	63,913	63,913	16
17	Accumulated Depreciation (book methods)	(31,203)	(31,203)	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)**	$ 119,889	$ 119,889	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 793,223	$ 793,223	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 374,604	$ 374,604	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	127,871	127,871	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,784	9,784	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	145,000	145,000	36
37	Accrued Expenses	59,800	59,800	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 717,059	$ 717,059	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	210,000	210,000	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)**	$ 210,000	$ 210,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 927,059	$ 927,059	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (133,836)	$ (133,836)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 793,223	$ 793,223	48

*(See instructions.)

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 465,726	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 465,726	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(599,562)	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)**	$ (599,562)	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)**	$ (133,836)	24 *

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

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,650,522	1
2	Discounts and Allowances for all Levels	(18,770)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,631,752	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	19,188	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 19,188	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***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Vending Income	525	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 525	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,651,465	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	616,989	31
32	Health Care	1,293,890	32
33	General Administration	760,477	33
	B. Capital Expense		
34	Ownership	325,430	34
	C. Ancillary Expense		
35	Special Cost Centers	5,649	35
36	Provider Participation Fee	178,904	36
	D. Other Expenses (specify):		
37	Bad Debt	69,688	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,251,027	40
41	**Income before Income Taxes (line 30 minus line 40)****	(599,562)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (599,562)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,345,943	44
45	Private Pay - Net Inpatient Revenue	212,809	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)	73,000	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,631,752	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 SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 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	2,232	2,359	$ 61,890	$ 26.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,862	6,969	160,766	23.07	3
4	Licensed Practical Nurses	11,507	12,062	267,017	22.14	4
5	CNAs & Orderlies	32,561	34,288	462,235	13.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,848	4,105	50,504	12.30	10
11	Social Service Workers	6,572	6,703	84,455	12.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,964	13,879	148,646	10.71	15
16	Dishwashers					16
17	Maintenance Workers	705	705	12,953	18.37	17
18	Housekeepers	9,339	10,144	88,115	8.69	18
19	Laundry	6,188	6,276	57,305	9.13	19
20	Administrator	1,645	1,780	50,415	28.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,690	1,824	27,956	15.33	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	2,022	2,151	27,203	12.65	31
32	Other Health Care(specify)					32
33	Other(specify) MDS Coordinator	2,014	2,115	65,552	30.99	33
34	TOTAL (lines 1 - 33)	100,149	105,360	$ 1,565,012 *	$ 14.85	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	133	$ 6,298	1 - 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	565	19,765	10 - 3	38
39	Pharmacist Consultant	122	6,093	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	116	6,377	12 - 3	45
46	Other(specify) MDS Consultant	446	15,623	10 - 3	46
47	HR Corporate Compliance Conslt	328	16,403	21 - 3	47
48	Marketing Consultant	109	5,459	19 - 3	48
49	TOTAL (lines 35 - 48)	1,819	$ 76,018		49

C. CONTRACT NURSES

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

Facility Name & ID Number INTEGRITY HC OF SMITHTON # 0053298 Report Period Beginning: 01/01/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Foster Chad E	Administrator	0	$ 38,104
Wingerter Lauriel	Administrator	0	12,311
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 50,415

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Sandberg Phoenix	Collections	$ 2,509
Bradley & Associates	Accounting Fees	900
Johnson, Goldberg & Brown	Accounting Fees	3,000
Senior Healthcare - Polsinelli	Legal Fees	818
Senior Healthcare	Management Fees	192,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 199,227

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,893
Unemployment Compensation Insurance	15,338
FICA Taxes	103,166
Employee Health Insurance	53,546
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	7,098
TOTAL (agree to Schedule V, line 22, col.8)	$ 220,041

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Illinois Council on LTC	4,200
Various	1,954
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,134

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Auto Allowance	6,222
Mileage	1,231
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,453

**See instructions.

Facility Name & ID Number **INTEGRITY HC OF SMITHTON** **# 0053298** **Report Period Beginning: 01/01/18** **Ending: 12/31/18**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **Illinois Council $4,200**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,869** Line **10 - 2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **178,904**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100 %**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **N/A**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees