



Facility Name & ID Number INTEGRITY HC OF CARBONDALE

# 0051029 Report Period Beginning: 01/01/20 Ending: 12/31/20

**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** NA

	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	131	Skilled (SNF)	131	47,946	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	131	TOTALS	131	47,946	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	16,350	362	5,076	21,788	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,350	362	5,076	21,788	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 45.44%

**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 06/01/10

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

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 131 and days of care provided 4,111

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: 12/31/20 Fiscal Year: 12/31/20

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

Facility Name & ID Number **INTEGRITY HC OF CARBONDALE** # **0051029** Report Period Beginning: **01/01/20** Ending: **12/31/20**

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	176,125	13,082	6,166	195,373		195,373	(10)	195,363		1
2	Food Purchase		143,366		143,366		143,366		143,366		2
3	Housekeeping	159,527	10,548		170,075		170,075		170,075		3
4	Laundry	51,234	9,630		60,864		60,864		60,864		4
5	Heat and Other Utilities			167,104	167,104		167,104	2,491	169,595		5
6	Maintenance	39,767	17,110	53,727	110,604		110,604	2,264	112,868		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	426,653	193,736	226,997	847,386		847,386	4,745	852,131		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			19,738	19,738		19,738		19,738		9
10	Nursing and Medical Records	1,522,233	250,193	45,678	1,818,104		1,818,104	64,574	1,882,678		10
10a	Therapy			445,111	445,111		445,111		445,111		10a
11	Activities	35,029	1,391		36,420		36,420		36,420		11
12	Social Services	65,349		4,719	70,068		70,068		70,068		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>RX Consultant</b>			6,525	6,525		6,525		6,525		15
16	<b>TOTAL Health Care and Programs</b>	1,622,611	251,584	521,771	2,395,966		2,395,966	64,574	2,460,540		16
	<b>C. General Administration</b>										
17	Administrative	57,010			57,010		57,010		57,010		17
18	Directors Fees										18
19	Professional Services			249,812	249,812		249,812	(166,115)	83,697		19
20	Dues, Fees, Subscriptions & Promotions			12,658	12,658		12,658	79	12,737		20
21	Clerical & General Office Expenses	50,130	18,873	98,398	167,401		167,401	91,266	258,667		21
22	Employee Benefits & Payroll Taxes			259,184	259,184		259,184	100,825	360,009		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,206	2,206		2,206	3,051	5,257		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			304,486	304,486		304,486	623	305,109		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	107,140	18,873	926,744	1,052,757		1,052,757	29,728	1,082,485		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,156,404	464,193	1,675,512	4,296,109		4,296,109	99,047	4,395,156		29

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

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

Facility Name & ID Number INTEGRITY HC OF CARBONDALE

#0051029

Report Period Beginning:

01/01/20

Ending:

12/31/20

## 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	
	<b>D. Ownership</b>											
30	Depreciation			101,011	101,011		101,011	(36,423)	64,588			30
31	Amortization of Pre-Op. & Org.			815	815		815		815			31
32	Interest			22,417	22,417		22,417	(3,275)	19,142			32
33	Real Estate Taxes			49,435	49,435		49,435		49,435			33
34	Rent-Facility & Grounds			448,282	448,282		448,282	9,613	457,895			34
35	Rent-Equipment & Vehicles							1,026	1,026			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			621,960	621,960		621,960	(29,059)	592,901			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,792		171,792		171,792		171,792			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,686	187,686		187,686		187,686			42
43	Other (specify):* <b>Bad Debt Expense</b>			152,764	152,764		152,764	(152,764)				43
44	<b>TOTAL Special Cost Centers</b>		171,792	340,450	512,242		512,242	(152,764)	359,478			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,156,404	635,985	2,637,922	5,430,311		5,430,311	(82,776)	5,347,535			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	(36,423)	30		9
10	Interest and Other Investment Income	(3,275)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,925)	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	(152,764)	43		24
25	Fund Raising, Advertising and Promotional	(14,606)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (210,003)		\$	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)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 127,227		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (82,776)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

ID# 0051029

Report Period Beginning: 01/01/20

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number INTEGRITY HC OF CARBONDALE

# 0051029

Report Period Beginning:

01/01/20

Ending:

12/31/20

## 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	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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	2,491	0	0	0	0	0	0	0	0	0	2,491	5
6	Maintenance	0	2,264	0	0	0	0	0	0	0	0	0	2,264	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(10)</b>	<b>4,755</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,745</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	26,365	38,209	0	0	0	0	0	0	0	0	64,574	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>26,365</b>	<b>38,209</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>64,574</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(166,115)	0	0	0	0	0	0	0	0	0	(166,115)	19
20	Fees, Subscriptions & Promotions	0	79	0	0	0	0	0	0	0	0	0	79	20
21	Clerical & General Office Expenses	(17,531)	108,097	700	0	0	0	0	0	0	0	0	91,266	21
22	Employee Benefits & Payroll Taxes	0	18,953	81,872	0	0	0	0	0	0	0	0	100,825	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,051	0	0	0	0	0	0	0	0	0	3,051	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	623	0	0	0	0	0	0	0	0	0	623	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(17,531)</b>	<b>(35,313)</b>	<b>82,572</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>29,728</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(17,541)</b>	<b>(4,193)</b>	<b>120,781</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>99,047</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number INTEGRITY HC OF CARBONDALE # 0051029 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(36,423)	0	0	0	0	0	0	0	0	0	0	(36,423) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(3,275)	0	0	0	0	0	0	0	0	0	0	(3,275) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	9,613	0	0	0	0	0	0	0	0	0	9,613 34
35	Rent-Equipment & Vehicles	0	1,026	0	0	0	0	0	0	0	0	0	1,026 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>(39,698)</b>	<b>10,639</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(29,059) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(152,764)	0	0	0	0	0	0	0	0	0	0	(152,764) 43
44	<b>TOTAL Special Cost Centers</b>	<b>(152,764)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(152,764) 44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(210,003)</b>	<b>6,446</b>	<b>120,781</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(82,776) 45</b>



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steven Blisko	60	Integrity HC of Cobden	Cobden	Integrity HCC Services	Skokie	Consulting Co.
A&F Realty LLC	35	Integrity HC of Alton	Alton			
Ted Lerman	5	Integrity HC of Belleville	Belleville			
		Integrity HC of Columbia	Columbia			
		Integrity HC of Herrin	Herrin			
		Integrity HC of Anna	Anna			
		Integrity HC of Smithton	Smithton			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	5 Heat and Other Utilities	\$	Integrity HCC Services		\$ 2,491	\$ 2,491	1	
2	V	6 Maintenance		Integrity HCC Services		2,264	2,264	2	
3	V	10 Nursing and Medical Records		Integrity HCC Services		26,365	26,365	3	
4	V	19 Professional Services	216,000	Integrity HCC Services		49,885	(166,115)	4	
5	V	20 Dues, Fees, Subscriptions & Promotions		Integrity HCC Services		79	79	5	
6	V	21 Clerical & General Office Expenses		Integrity HCC Services		108,097	108,097	6	
7	V	22 Employee Benefits & Payroll Taxes		Integrity HCC Services		18,953	18,953	7	
8	V	24 Travel and Seminar		Integrity HCC Services		3,051	3,051	8	
9	V	26 Insurance-Prop.Liab.Malpractice		Integrity HCC Services		623	623	9	
10	V	34 Rent		Integrity HCC Services		9,613	9,613	10	
11	V	35 Equipment Lease		Integrity HCC Services		1,026	1,026	11	
12	V							12	
13	V							13	
14	Total		\$ 216,000			\$ 222,446	\$ *	6,446	14

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing and Medical Records	\$ 139,583	Integrity Communities		\$ 177,792	\$ 38,209	15
16	V	21 Clerical & General Office Expenses		Integrity Communities		700	700	16
17	V	22 Employee Benefits & Payroll Taxes		Integrity Communities		81,872	81,872	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$ 139,583			\$ 260,364	\$ * 120,781	39

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

Facility Name & ID Number

INTEGRITY HC OF CARBONDALE

# 0051029

Report Period Beginning:

01/01/20

Ending:

12/31/20

**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 Wood River	Wood River				1
2			Integrity HC of Godfrey	Godfrey				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

Facility Name & ID Number INTEGRITY HC OF CARBONDALE # 0051029 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 CARBONDALE

# 0051029

Report Period Beginning:

01/01/20

Ending: 12/31/20

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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.

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

Facility Name & ID Number

INTEGRITY HC OF CARBONDALE

# 0051029

Report Period Beginning:

01/01/20

Ending:

12/31/20

**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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1						\$	\$			\$	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6											6							
7											7							
8											8							
9	<b>TOTAL Facility Related</b>					\$	\$			\$	9							
<b>B. Non-Facility Related*</b>																		
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ NA                      Line # \_\_\_\_\_

\* 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 2019 report.		\$	<b>(57,892)</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>49,830</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>107,722</b>	<b>3</b>
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	<b>(58,287)</b>	<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>49,435</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	<b>46,354</b>	<b>8</b>	
	2016	<b>46,674</b>	<b>9</b>	
	2017	<b>47,803</b>	<b>10</b>	
	2018	<b>48,381</b>	<b>11</b>	
	2019	<b>49,830</b>	<b>12</b>	
				<b>FOR BHF USE ONLY</b>
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2019	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

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.**

**2019 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME INTEGRITY HC OF CARBONDALE COUNTY Jackson

FACILITY IDPH LICENSE NUMBER 0051029

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

TELEPHONE 773-747-4506 FAX #: 773-747-4725

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-19-126-004</u>	<u>Long Term Care Property</u>	\$ <u>49,829.88</u>	\$ <u>49,829.88</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>49,829.88</u></u>	\$ <u><u>49,829.88</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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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



X. BUILDING AND GENERAL INFORMATION:

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:

1. Total Amount Incurred: 12,225 2. Number of Years Over Which it is Being Amortized: 15  
3. Current Period Amortization: 815 4. Dates Incurred: Prior to 06/01/10

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

XI. OWNERSHIP COSTS:

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Cooling System		2010	22,782	584	39	584		6,132
10									
11	Sprinklers		2011	319,061	8,181	39	8,181		76,356
12	Concrete Work		2011	29,900	767	39	767		7,030
13	Roof		2011	98,000	2,513	39	2,513		23,031
14									
15	Rooftop Condenser and 5 Ton Bryant Gas/ Elect Unit		2013	16,513	423	39	423		3,174
16	Drain Pipe System in hallways and kitchen		2013	28,982	743	39	743		5,573
17	Wiring for Nurse Stations and Kiosks		2013	19,151	491	39	491		3,601
18									
19	Paint Halls in South Hallway		2014	11,361	291	39	291		2,038
20									
21	Skim coat and paint walls in south hallway		2015	11,361	291	39	291		1,589
22	Redo asphalt in front & back parking lots		2015	62,000	1,590	39	1,590		8,678
23									
24	30 chrome faucet and 100 door handles		2016	2,852	73	39	73		326
25	Plumbing shields max ADA covers		2016	1,665	43	39	43		191
26	Architectural Services for IDPH review		2016	8,502	218	39	218		972
27	Negative air fan / Air Scrubbler, HEPA vacuuming, clean walls		2016	71,199	1,826	39	1,826		8,139
28	and ceiling, clean floors, remove suspended ceiling tile								
29	in rooms 1, 3-8, 10-26, 31 - 36, break room, bathroom								
30	and kitchen.								
31	Painted courtyards and new siding		2016	2,700	69	39	69		308
32	Kawneer swing doors		2016	2,320	59	39	59		264
33	Sewer line replacement		2016	8,800	226	39	226		1,006
34									
35									
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 &amp; ID Number INTEGRITY HC OF CARBONDALE

# 0051029

Report Period Beginning:

01/01/20

Ending:

12/31/20

**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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Tile and new carpet for Vestibule, install ceiling system and	2016	\$ 77,218	\$ 1,980	39	\$ 1,826	\$ (154)	\$ 8,828	37
38	lighting in lobby, install tile, cove base and carpeting in lobby,								38
39	install reception desk, pendant light and drywall in lobby.								39
40	Lobby window tinting	2016	10,498	269	39	269		1,199	40
41	Waterproofing basement	2016	9,610	246	39	246		1,098	41
42	Call light system	2016	35,649	914	39	914		4,075	42
43									43
44	Paint 56 patient rooms and bathrooms	2017	93,409	2,395	39	2,395		8,384	44
45	Sewer line service	2017	104,923	2,690	39	2,690		9,416	45
46	Deaved egress install	2017	5,969	153	39	153		537	46
47	Condensing unit install	2017	5,625	144	39	144		504	47
48	New Roof	2017	91,310	2,341	39	2,341		8,196	48
49	Blackout roller shades installed in 29 resident rooms	2017	27,781	712	39	712		2,493	49
50	New HVAC and blower assembly	2017	11,814	303	39	303		1,059	50
51									51
52	Sewer line repair - replacing 60 feet of 4" cast iron sewer	2018	199,786	5,123	39	5,123		12,806	52
53	Installing new flooring	2018	113,594	2,913	39	2,913		7,281	53
54	Installation of new flat Lexan Face replacement for existing sign	2018	1,223	31	39	31		79	54
55	Installation of closet system in 10 rooms	2018	1,747	45	39	45		112	55
56	Replacement of existing air conditioning - Trane	2018	15,000	385	39	385		961	56
57									57
58	Sewer Lines	2019	160,000	4,103	39	4,103		6,154	58
59	New Interior Vestibule	2019	3,990	102	39	77	(26)	153	59
60	New Interior Vestibule	2019	3,990	102	39	77	(26)	153	60
61	Washer Installation	2019	9,459	243	39	40	(202)	364	61
62	Fire Alarm Repairs	2019	6,725	172	39	29	(144)	259	62
63	New Door	2019	3,919	100	39	8	(92)	151	63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,710,387	\$ 43,856		\$ 43,213	\$ (643)	\$ 222,672	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	\$ 85,347	\$ 14,078	\$ 17,069	\$ 2,991	5	\$ 72,782	71
72	Current Year Purchases	43,079	43,079	4,308	(38,771)	5	43,079	72
73	Fully Depreciated Assets	121,799				5	121,799	73
74								74
75	<b>TOTALS</b>	\$ 250,225	\$ 57,157	\$ 21,377	\$ (35,780)		\$ 237,660	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	<b>TOTALS</b>			\$	\$	\$	\$		\$	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)	\$ 1,960,612	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,013	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,590	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (36,423)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 460,332	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	<b>TOTALS</b>	\$	\$	\$	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: 120 North Tower Road LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1995</u>	<u>131</u>	<u>08/01/15</u>	\$	<u>20</u>	<u>N/A</u>	3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>		<b>131</b>		\$			<b>7</b>

10. Effective dates of current rental agreement:

Beginning 06/01/10

Ending 05/31/30

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

Fiscal Year Ending Annual Rent

12.	<u>12/2021</u>	\$ <u>464,214</u>
13.	<u>12/2022</u>	\$ <u>478,140</u>
14.	<u>12/2023</u>	\$ <u>492,484</u>

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

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

N/A

N/A

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,768	\$ 176,522				2,768	\$ 176,522					1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		943	81,858				943	81,858					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs		2,420	186,731				2,420	186,731					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							171,792					171,792	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>X-ray</u>	39-2								6,050					6,050	12
13	Other (specify): <u>Lab</u>	39-2								5,442					5,442	13
14	<b>TOTAL</b>			\$	6,132	\$ 445,111				\$ 183,284			6,132	\$ 628,395		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 **12/31/20**

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (41,333)	\$ (41,333)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,548,885	1,548,885	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	397,271	397,271	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,904,823	\$ 1,904,823	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,570,385	1,570,385	15
16	Equipment, at Historical Cost	250,225	250,225	16
17	Accumulated Depreciation (book methods)	(460,325)	(460,325)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(8,625)	(8,625)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,363,885	\$ 1,363,885	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,268,708	\$ 3,268,708	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 974,026	\$ 974,026	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	370,760	370,760	29
30	Accrued Salaries Payable	142,241	142,241	30
31	Accrued Taxes Payable (excluding real estate taxes)			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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,487,027	\$ 1,487,027	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,250,000	1,250,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,250,000	\$ 1,250,000	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,737,027	\$ 2,737,027	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 531,681	\$ 531,681	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,268,708	\$ 3,268,708	48

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(640,533)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(640,533)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,172,216</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>1,172,216</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Rounding</b>	<b>(2)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(2)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>531,681</b>	<b>24</b> *

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

Facility Name &amp; ID Number INTEGRITY HC OF CARBONDALE

# 0051029

Report Period Beginning: 01/01/20

Ending: 12/31/20

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,209,058	1
2	Discounts and Allowances for all Levels	(139,762)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,069,296	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	139,011	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 139,011	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	1,389,039	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,389,039	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	3,275	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,275	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>Misc Rev</b>	1,906	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,906	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,602,527	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	847,386	31
32	Health Care	2,395,966	32
33	General Administration	1,052,757	33
<b>B. Capital Expense</b>			
34	Ownership	621,960	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	512,242	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,430,311	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,172,216	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,172,216	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,849,634	44
45	Private Pay - Net Inpatient Revenue	75,735	45
46	Medicare - Net Inpatient Revenue	1,956,617	46
47	Other-(specify) <b>Net Patient Revenue</b>	187,310	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,069,296	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? 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 CARBONDALE

# 0051029

Report Period Beginning: 01/01/20

Ending: 12/31/20

12/31/20

**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	5,574	5,737	\$ 82,616	\$ 14.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,501	3,501	372,469	106.39	3
4	Licensed Practical Nurses	20,642	21,158	485,164	22.93	4
5	CNAs & Orderlies	26,324	27,127	505,959	18.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants			35,029		10
11	Social Service Workers	1,950	2,038	65,349	32.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,446	9,768	176,125	18.03	15
16	Dishwashers					16
17	Maintenance Workers	1,922	1,974	39,767	20.15	17
18	Housekeepers	12,744	13,307	159,527	11.99	18
19	Laundry	5,276	5,485	51,234	9.34	19
20	Administrator	2,080	2,080	57,010	27.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,776	5,003	50,130	10.02	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	2,339	2,530	76,026	30.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,574	99,708	\$ 2,156,405 *	\$ 21.63	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	Monthly	\$ 6,166	1-3	35
36	Medical Director	Monthly	19,738	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	30,017	10-3	38
39	Pharmacist Consultant	Monthly	6,525	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	Monthly	4,719	12-3	45
46	Other(specify) <u>MDS</u>	Monthly	15,662	10-3	46
47	<u>HR Corp Compliance</u>	Monthly	18,650	21-3	47
48	<u>MARKETING CONSULTANT</u>	Monthly	13,634	21-3	48
49	TOTAL (lines 35 - 48)	Monthly	\$ 115,110		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	
Hamm, Michelle L.	Administrator	0	\$ 57,010	Workers' Compensation Insurance	\$ 47,666	IDPH License Fee	\$ 1,650	
				Unemployment Compensation Insurance	18,649	Advertising: Employee Recruitment		
				FICA Taxes	258,279	Health Care Worker Background Check		
				Employee Health Insurance	27,506	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Secretary of State	238	
				Employee Benefits Other	7,909	HCCI	4,200	
						Carbondale Chamber of Commerce	523	
						Jackson County Health Dept	280	
						Other fees	5,846	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 57,010			Less: Public Relations Expense	( )	
(List each licensed administrator separately.)						Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,737	
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Bradley & Associates	Accounting Fees		\$ 6,388			\$	Out-of-State Travel	\$
Johnson, Goldberg, & Brown	Accounting Fees		3,000					
GGM Associates Inc	Accounting Fees		6,000					
Integrity HCC	Management Fees		216,000				In-State Travel	
BANK LEUMI	Legal Fees		6,473				AUTO ALLOWANCE	466
MTS CONSULTING LLC	Professional Fees		4,981				Mileage Reimbursement	4,792
Integrity HCC Services LLC	Professional Fees		500					
Sandberg Phoenix & Von Gontard P.	Collection Costs		6,171				Seminar Expense	
MARKOFF LAW LLC	Collection Costs		300					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 249,812	TOTAL		\$	Entertainment Expense	( )
(For legal fee disclosure, see page 39 of instructions)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 5,258

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number INTEGRITY HC OF CARBONDALE

# 0051029

Report Period Beginning:

01/01/20

Ending:

12/31/20

**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. HCCI \$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 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,844 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 187,686  
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? No
- (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. \$ 0 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? YES  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 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.