

		FOR BHF USE					

LL1

**2020**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2020)**

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

<p><b>I. IDPH License ID Number:</b> <u>0051381</u></p> <p><b>Facility Name:</b> <u>INTEGRITY HC OF COLUMBIA</u></p> <p><b>Address:</b> <u>253 Bradington Drive</u> <u>Columbia</u> <u>62236</u>  Number City Zip Code</p> <p><b>County:</b> <u>Monroe</u></p> <p><b>Telephone Number:</b> <u>708-426-2315</u> Fax # <u>708-426-2415</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>04/01/11</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width: 33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width: 33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  Name: <u>Aaron Mauer</u> Telephone Number: <u>773-747-4506</u>  Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ <u>5/28/2021</u> (Date)</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Type or Print Name) <u>Alan Irni</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Title) <u>CFO</u></td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ <u>5/27/2021</u> (Date)</td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Print Name and Title) <u>Aaron Mauer</u> <u>President</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Firm Name &amp; Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtzy Parkway South Bend IN 46628</u></td> </tr> <tr> <td style="padding: 5px;"></td> <td style="padding: 5px;">(Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u></td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ <u>5/28/2021</u> (Date)		(Type or Print Name) <u>Alan Irni</u>		(Title) <u>CFO</u>	Paid Preparer	(Signed) _____ <u>5/27/2021</u> (Date)		(Print Name and Title) <u>Aaron Mauer</u> <u>President</u>		(Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtzy Parkway South Bend IN 46628</u>		(Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																					
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																					
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																					
	<input type="checkbox"/> "Sub-S" Corp.																																						
	<input checked="" type="checkbox"/> Limited Liability Co.																																						
	<input type="checkbox"/> Trust																																						
	<input type="checkbox"/> Other _____																																						
Officer or Administrator of Provider	(Signed) _____ <u>5/28/2021</u> (Date)																																						
	(Type or Print Name) <u>Alan Irni</u>																																						
	(Title) <u>CFO</u>																																						
Paid Preparer	(Signed) _____ <u>5/27/2021</u> (Date)																																						
	(Print Name and Title) <u>Aaron Mauer</u> <u>President</u>																																						
	(Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtzy Parkway South Bend IN 46628</u>																																						
	(Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u>																																						

Facility Name & ID Number INTEGRITY HC OF COLUMBIA

# 0051381 Report Period Beginning: 1/1/20 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	119	Skilled (SNF)	119	43,554	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	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	15,003	4,892	3,424	23,319	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,003	4,892	3,424	23,319	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.54%

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 04/01/11

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 04/01/11 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 119 and days of care provided 3,052

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 COLUMBIA** # **0051381** Report Period Beginning: **1/1/20** 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	181,608	12,717	8,090	202,415		202,415	(141)	202,274		1
2	Food Purchase		145,851		145,851		145,851		145,851		2
3	Housekeeping	178,832	10,424		189,256		189,256		189,256		3
4	Laundry	48,627	10,578		59,205		59,205		59,205		4
5	Heat and Other Utilities			145,891	145,891		145,891	2,975	148,866		5
6	Maintenance	54,447	34,779	22,000	111,226		111,226	2,704	113,930		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	463,514	214,349	175,981	853,844		853,844	5,539	859,383		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			24,100	24,100		24,100		24,100		9
10	Nursing and Medical Records	1,676,778	206,759	48,848	1,932,385		1,932,385	102,371	2,034,756		10
10a	Therapy			684,436	684,436		684,436		684,436		10a
11	Activities	79,316	2,915		82,231		82,231		82,231		11
12	Social Services	50,654		5,685	56,339		56,339		56,339		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>RX Consultant</b>			6,939	6,939		6,939		6,939		15
16	<b>TOTAL Health Care and Programs</b>	1,806,748	209,674	770,008	2,786,430		2,786,430	102,371	2,888,801		16
	<b>C. General Administration</b>										
17	Administrative	87,219			87,219		87,219		87,219		17
18	Directors Fees										18
19	Professional Services			286,411	286,411		286,411	(198,416)	87,995		19
20	Dues, Fees, Subscriptions & Promotions			9,165	9,165		9,165	94	9,259		20
21	Clerical & General Office Expenses	62,649	22,980	111,179	196,808		196,808	109,172	305,980		21
22	Employee Benefits & Payroll Taxes			306,341	306,341		306,341	174,518	480,859		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,712	5,712		5,712	3,644	9,356		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			322,983	322,983		322,983	744	323,727		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	149,868	22,980	1,041,791	1,214,639		1,214,639	89,758	1,304,397		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,420,130	447,003	1,987,780	4,854,913		4,854,913	197,668	5,052,581		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					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			69,894	69,894		69,894	(32,860)	37,034		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			32,770	32,770		32,770	14	32,784		32
33	Real Estate Taxes			71,447	71,447		71,447		71,447		33
34	Rent-Facility & Grounds			985,918	985,918		985,918	11,482	997,400		34
35	Rent-Equipment & Vehicles							1,226	1,226		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			1,160,029	1,160,029		1,160,029	(20,138)	1,139,891		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation			1,571	1,571		1,571		1,571		38
39	Ancillary Service Centers		114,359		114,359		114,359		114,359		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			189,687	189,687		189,687		189,687		42
43	Other (specify):* <b>Bad Debt Expense</b>			102,013	102,013		102,013	(102,013)			43
44	<b>TOTAL Special Cost Centers</b>		114,359	293,271	407,630		407,630	(102,013)	305,617		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,420,130	561,362	3,441,080	6,422,572		6,422,572	75,517	6,498,089		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	(32,860)	30		9
10	Interest and Other Investment Income	14	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(141)	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	(4,550)	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	(102,013)	43		24
25	Fund Raising, Advertising and Promotional	(16,692)	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>	\$ (156,242)		\$	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>	\$ 231,759	Various	36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 75,517		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# 0051381

Report Period Beginning: 1/1/20

Ending: 12/31/20

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 & ID Number INTEGRITY HC OF COLUMBIA

# 0051381

Report Period Beginning:

1/1/20

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	(141)	0	0	0	0	0	0	0	0	0	0	(141)	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	2,975	0	0	0	0	0	0	0	0	0	2,975	5
6	Maintenance	0	2,704	0	0	0	0	0	0	0	0	0	2,704	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(141)</b>	<b>5,680</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>5,539</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	31,491	70,880	0	0	0	0	0	0	0	0	102,371	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>31,491</b>	<b>70,880</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>102,371</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	(198,416)	0	0	0	0	0	0	0	0	0	(198,416)	19
20	Fees, Subscriptions & Promotions	0	94	0	0	0	0	0	0	0	0	0	94	20
21	Clerical & General Office Expenses	(21,242)	129,115	1,299	0	0	0	0	0	0	0	0	109,172	21
22	Employee Benefits & Payroll Taxes	0	22,638	151,880	0	0	0	0	0	0	0	0	174,518	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,644	0	0	0	0	0	0	0	0	0	3,644	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	744	0	0	0	0	0	0	0	0	0	744	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(21,242)</b>	<b>(42,179)</b>	<b>153,179</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>89,758</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(21,383)</b>	<b>(5,008)</b>	<b>224,059</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>197,668</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number INTEGRITY HC OF COLUMBIA# 0051381

Report Period Beginning:

1/1/20

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	(32,860)	0	0	0	0	0	0	0	0	0	0	(32,860)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	14	0	0	0	0	0	0	0	0	0	0	14	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	11,482	0	0	0	0	0	0	0	0	0	11,482	34
35	Rent-Equipment & Vehicles	0	1,226	0	0	0	0	0	0	0	0	0	1,226	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(32,846)</b>	<b>12,708</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>(20,138)</b>	<b>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):*	(102,013)	0	0	0	0	0	0	0	0	0	0	(102,013)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(102,013)</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>(102,013)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(156,242)</b>	<b>7,700</b>	<b>224,059</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>75,517</b>	<b>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 Carbonedale	Carbonedale	Integrity HCC Serivces	Skokie	Consulting Co.
A&F Realty LLC	35	Integrity HC of Alton	Alton			
Ted Lerman	5	Integrity HC of Belleville	Belleville			
		Integrity HC of Cobden	Cobden			
		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 Serivces		\$ 2,975	\$ 2,975	1	
2	V	6 Maintenance		Integrity HCC Serivces		2,704	2,704	2	
3	V	10 Nursing and Medical Records		Integrity HCC Serivces		31,491	31,491	3	
4	V	19 Professional Services	258,000	Integrity HCC Serivces		59,584	(198,416)	4	
5	V	20 Dues, Fees, Subscriptions & Promotions		Integrity HCC Serivces		94	94	5	
6	V	21 Clerical & General Office Expenses		Integrity HCC Serivces		129,115	129,115	6	
7	V	22 Employee Benefits & Payroll Taxes		Integrity HCC Serivces		22,638	22,638	7	
8	V	24 Travel and Seminar		Integrity HCC Serivces		3,644	3,644	8	
9	V	26 Insurance-Prop.Liab.Malpractice		Integrity HCC Serivces		744	744	9	
10	V	34 Rent		Integrity HCC Serivces		11,482	11,482	10	
11	V	35 Equipment Lease		Integrity HCC Serivces		1,226	1,226	11	
12	V							12	
13	V							13	
14	Total		\$ 258,000			\$ 265,700	\$ *	7,700	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	\$ 258,939	Integrity Communities Services		\$ 329,819	\$ 70,880	15
16	V	21 Clerical & General Office Expenses		Integrity Communities Services		1,299	1,299	16
17	V	22 Employee Benefits & Payroll Taxes		Integrity Communities Services		151,880	151,880	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	Total		\$ 258,939			\$ 482,998	\$ * 224,059	39

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

Facility Name & ID Number

INTEGRITY HC OF COLUMBIA

# 0051381

Report Period Beginning:

1/1/20

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 COLUMBIA # 0051381 Report Period Beginning: 1/1/20 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 COLUMBIA

# 0051381

Report Period Beginning:

1/1/20

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 COLUMBIA

# 0051381

Report Period Beginning:

1/1/20

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<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>(21,778)</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>83,590</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>105,368</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>(33,921)</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>71,447</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2015	<b>64,952</b>	<b>8</b>	
	2016	<b>84,865</b>	<b>9</b>	
	2017	<b>85,772</b>	<b>10</b>	
	2018	<b>86,408</b>	<b>11</b>	
	2019	<b>83,590</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 COLUMBIA COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0051381

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>04-17-481-004-000</u>	<u>Long Term Care Property</u>	\$ <u>56,507.32</u>	\$ <u>56,507.32</u>
2. <u>04-17-481-028-000</u>	<u>Long Term Care Property</u>	\$ <u>26,357.22</u>	\$ <u>26,357.22</u>
3. <u>04-17-481-005-000</u>	<u>Long Term Care Property</u>	\$ <u>725.82</u>	\$ <u>725.82</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>83,590.36</u></u>	\$ <u><u>83,590.36</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: 32,709 B. General Construction Type: Exterior Brick Frame Concrete / Steel 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).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a numbered column (1-3). Row 3 is shaded and labeled 'TOTALS'.

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Signs		2011		2,646		39			2,646
10										
11	Fire Alarm		2013		2,731	70	39	70		525
12	Rewiring Nurse Stations and Kiosks		2013		17,798	456	39	456		3,345
13										
14	Shut off and drain sprinkler system		2014		3,287	84	39	84		589
15	Service trip for security system		2014		1,895	49	39	49		342
16	10 zone conventional fire panel		2014		3,307	85	39	85		595
17	New Sprinkler heads / pipes/ caps		2014		2,352	60	39	60		421
18										
19	Replace A/C, furnace and coil		2015		10,991	282	39	282		1,539
20										
21	New air compressor		2016		2,744	70	39	70		313
22	New Sprinkler heads		2016		2,157	55	39	55		247
23										
24	Install new furnace		2017		3,497	90	39	90		314
25	New Roof		2017		148,475	3,807	39	3,807		13,326
26	Water heater unit		2017		3,200	82	39	82		287
27	Remodel vestibule,lobby,guest bathrooms,offices, dining room		2017		711,767	18,250	39	18,250		63,876
28	Delayed egress		2017		8,387	215	39	215		754
29	Call light security system		2017		4,169	107	39	107		376
30										
31	Furnish and install Carrier Gas Furnace		2018		4,048	104	39	104		320
32	Call Light system for main nurses station		2018		1,200	31	39	31		77
33	Furnish and install AO Smith 100 gallon tank		2018		11,341	291	39	291		727
34	PCC kiosk wiring infrastructure		2018		1,473	38	39	38		95
35	Renovation		2018		154,767	3,968	39	3,968		9,921
36										

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**

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

1	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	HVAC Replacement	2018	\$ 29,831	\$ 765	39	\$ 765	\$	\$ 1,912	37
38	Carrier Furnace	2018	4,695	120	39	120		241	38
39									39
40	Water Heater & Repair	2019	9,760	250	39	250		375	40
41	Sprinkler	2019	2,311	59	39	59		89	41
42	Install New Furnace	2019	1,867	48	39	48		72	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)		\$ 1,150,696	\$ 29,437		\$ 29,437	\$	\$ 103,320	70

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

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Costs-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 19,729	\$ 3,945	\$ 3,946	\$ 1	5	\$ 16,660	71
72	Current Year Purchases	36,512	36,512	3,651	(32,861)	5	36,512	72
73	Fully Depreciated Assets	202,579				5	202,579	73
74								74
75	<b>TOTALS</b>	\$ 258,820	\$ 40,457	\$ 7,597	\$ (32,860)		\$ 255,751	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)	\$ 1,409,516	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,894	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,034	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (32,860)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 359,071	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: 253 Bradington Drive, 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:		119	01/01/16	\$	20	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		119		\$			7

10. Effective dates of current rental agreement:

Beginning 01/01/16

Ending 01/01/36

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

Fiscal Year Ending Annual Rent

12.	<u>/2021</u>	\$ <u>1,035,654</u>
13.	<u>/2022</u>	\$ <u>1,066,724</u>
14.	<u>/2023</u>	\$ <u>1,098,726</u>

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

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

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

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

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

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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	\$	4,118	\$ 286,826				4,118	\$ 286,826					1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,796	147,578				1,796	147,578					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs		4,515	250,032				4,515	250,032					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							114,359					114,359	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								5,915					5,915	12
13	Other (specify): <u>Lab</u>	39-2								9,416					9,416	13
14	<b>TOTAL</b>			\$	10,429	\$ 684,436				\$ 129,690			10,429	\$ 814,126		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.

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	\$ 572,468	\$ 572,468	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	7,463,452	7,463,452	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	91,333	91,333	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 8,127,253	\$ 8,127,253	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	1,148,050	1,148,050	15
16	Equipment, at Historical Cost	259,959	259,959	16
17	Accumulated Depreciation (book methods)	(356,427)	(356,427)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,051,582	\$ 1,051,582	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 9,178,835	\$ 9,178,835	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,027,107	\$ 1,027,107	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	488,403	488,403	29
30	Accrued Salaries Payable	120,475	120,475	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>	\$ 1,635,985	\$ 1,635,985	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			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>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,635,985	\$ 1,635,985	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 7,542,850	\$ 7,542,850	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 9,178,835	\$ 9,178,835	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>7,388,143</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>7,388,143</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>154,710</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>154,710</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Rounidng</b>	<b>(3)</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>(3)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>7,542,850</b>	<b>24</b> *

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

Facility Name &amp; ID Number INTEGRITY HC OF COLUMBIA

# 0051381

Report Period Beginning: 1/1/20

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	\$ 5,337,382	1
2	Discounts and Allowances for all Levels	(135,461)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,201,921	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	633,804	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 633,804	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	106,580	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	303	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,429	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 111,312	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	(14)	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ (14)	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<b>Misc Income</b>	630,259	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 630,259	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,577,282	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	853,844	31
32	Health Care	2,786,430	32
33	General Administration	1,214,639	33
<b>B. Capital Expense</b>			
34	Ownership	1,160,029	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	407,630	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>	\$ 6,422,572	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	154,710	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 154,710	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,541,404	44
45	Private Pay - Net Inpatient Revenue	924,414	45
46	Medicare - Net Inpatient Revenue	1,698,050	46
47	Other-(specify) <u>Net Patient Revenue</u>	38,052	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,201,920	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 COLUMBIA

# 0051381

Report Period Beginning:

1/1/20

Ending:

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	2,080	2,080	\$ 71,988	\$ 34.61	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,310	7,490	380,341	50.78	3
4	Licensed Practical Nurses	8,938	9,181	389,317	42.40	4
5	CNAs & Orderlies	22,593	23,025	650,875	28.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,489	7,767	79,316	10.21	10
11	Social Service Workers	3,000	3,020	50,654	16.77	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,322	13,899	181,608	13.07	15
16	Dishwashers					16
17	Maintenance Workers	784	792	54,447	68.75	17
18	Housekeepers	11,461	12,139	178,832	14.73	18
19	Laundry	4,087	4,385	48,627	11.09	19
20	Administrator	143	143	87,219	609.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,341	7,563	62,649	8.28	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	3,225	3,289	93,730	28.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS</u>	3,603	3,733	90,528	24.25	33
34	TOTAL (lines 1 - 33)	95,376	98,506	\$ 2,420,131 *	\$ 24.57	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	\$ 8,090	1-3	35
36	Medical Director	Monthly	24,100	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	32,794	10-3	38
39	Pharmacist Consultant	Monthly	6,939	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	5,685	12-3	45
46	Other(specify) <u>MDS</u>	Monthly	16,054	10-3	46
47	<u>HR Corp Compliance</u>	Monthly	18,550	21-3	47
48	<u>MARKETING CONSULTANT</u>	Monthly	15,650	21-3	48
49	TOTAL (lines 35 - 48)		\$ 127,862		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	
BLAIR, BILLIE J.	Administrator	0	\$ 57,327	Workers' Compensation Insurance	\$ 81,971	IDPH License Fee	\$ 249	
Higgins, Gina M.	Administrator	0	29,892	Unemployment Compensation Insurance	17,384	Advertising: Employee Recruitment		
				FICA Taxes	278,861	Health Care Worker Background Check		
				Employee Health Insurance	87,097	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Clia Laboratory	180	
				Employee Other Benefits	15,546	HCCI	4,200	
						IL Office of State Fire Marshal	400	
						Secretary of State	230	
						Other fees	4,000	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	( )	
(List each licensed administrator separately.)			\$ 87,219			Non-allowable advertising	( )	
						Yellow page advertising	( )	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,259	
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			\$ 480,859	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
(Attach a copy of any management service agreement)				Description			Amount	
				Line #				
				Amount				
C. Professional Services								
Vendor/Payee	Type		Amount					
Integrity HCC	Management Fees		\$ 258,000				Out-of-State Travel	\$
Johnson, Goldberg, & Brown	Accounting Fees		3,000					
GGM Associates Inc	Accounting Fees		2,559					
							In-State Travel	
Polsinelli	Legal Fees		1,525				AUTO ALLOWANCE	4,704
BANK LEUMI	Legal Fees		1,250				Mileage Reimbursement	3,673
Sandberg Phoenix	Legal Fees		1,008					
MTS CONSULTING LLC	Professional Fees		10,821				Seminar Expense	
Integrity HCC Services LLC	Professional Fees		500				EDUCATION	979
Markoff Law LLC	Collection Costs		300					
Sandberg Phoenix & Von Gontard P.	Collection Costs		7,446				Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(For legal fee disclosure, see page 39 of instructions)			\$ 286,411				TOTAL	\$ 9,356

\* Attach copy of IMRF notifications

\*\*See instructions.

Facility Name &amp; ID Number INTEGRITY HC OF COLUMBIA

# 0051381

Report Period Beginning:

1/1/20

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. \$ 20,040 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. \$ 189,687  
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.