

Facility Name & ID Number INTEGRITY HC OF GODFREY

0053306 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	68	Skilled (SNF)	68	24,888	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,888	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	12,128	2,174	2,255	16,557	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,128	2,174	2,255	16,557	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.53%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

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

I. On what date did you start providing long term care at this location?
Date started 11/24/14

J. Was the facility purchased or leased after January 1, 1978?
YES Date 11/24/14 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 68 and days of care provided 1,861

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 GODFREY** # **0053306** 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
	A. General Services										
1	Dietary	158,453	12,022	4,054	174,529		174,529	(63)	174,466		1
2	Food Purchase		102,440		102,440		102,440		102,440		2
3	Housekeeping	122,381	9,681		132,062		132,062		132,062		3
4	Laundry	25,667	6,226		31,893		31,893		31,893		4
5	Heat and Other Utilities			95,872	95,872		95,872	2,283	98,155		5
6	Maintenance	36,964	21,309	14,081	72,354		72,354	2,076	74,430		6
7	Other (specify):*										7
8	TOTAL General Services	343,465	151,678	114,007	609,150		609,150	4,296	613,446		8
	B. Health Care and Programs										
9	Medical Director			22,323	22,323		22,323		22,323		9
10	Nursing and Medical Records	1,231,598	194,739	48,706	1,475,043		1,475,043	36,092	1,511,135		10
10a	Therapy			275,491	275,491		275,491		275,491		10a
11	Activities	62,104	3,719		65,823		65,823		65,823		11
12	Social Services	22,686		5,330	28,016		28,016		28,016		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* RX Consultant			5,076	5,076		5,076		5,076		15
16	TOTAL Health Care and Programs	1,316,388	198,458	356,926	1,871,772		1,871,772	36,092	1,907,864		16
	C. General Administration										
17	Administrative	66,617			66,617		66,617		66,617		17
18	Directors Fees										18
19	Professional Services			226,560	226,560		226,560	(152,273)	74,287		19
20	Dues, Fees, Subscriptions & Promotions			11,521	11,521		11,521	72	11,593		20
21	Clerical & General Office Expenses	33,531	22,697	92,984	149,212		149,212	81,778	230,990		21
22	Employee Benefits & Payroll Taxes			248,648	248,648		248,648	42,923	291,571		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,005	1,005		1,005	2,797	3,802		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			149,732	149,732		149,732	571	150,303		26
27	Other (specify):*										27
28	TOTAL General Administration	100,148	22,697	730,450	853,295		853,295	(24,132)	829,163		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,760,001	372,833	1,201,383	3,334,217		3,334,217	16,255	3,350,472		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 GODFREY

#0053306

Report Period Beginning:

1/1/20

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	
	D. Ownership											
30	Depreciation			38,082	38,082		38,082	(16,408)	21,674			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,081	21,081		21,081	(1,454)	19,627			32
33	Real Estate Taxes			38,968	38,968		38,968		38,968			33
34	Rent-Facility & Grounds			240,238	240,238		240,238	8,812	249,050			34
35	Rent-Equipment & Vehicles							941	941			35
36	Other (specify):*											36
37	TOTAL Ownership			338,369	338,369		338,369	(8,109)	330,260			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			525	525		525		525			38
39	Ancillary Service Centers		112,287		112,287		112,287		112,287			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,282	133,282		133,282		133,282			42
43	Other (specify):* Bad Debt Expense			214,765	214,765		214,765	(214,765)				43
44	TOTAL Special Cost Centers		112,287	348,572	460,859		460,859	(214,765)	246,094			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,760,001	485,120	1,888,324	4,133,445		4,133,445	(206,619)	3,926,826			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	(16,408)	30		9
10	Interest and Other Investment Income	(1,454)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(214,765)	43		24
25	Fund Raising, Advertising and Promotional	(17,529)	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	SUBTOTAL (A): (Sum of lines 1-29)	\$ (250,219)		\$	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	SUBTOTAL (B): (sum of lines 31-35)	\$ 43,600	Various	36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (206,619)		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

ID# 0053306

Report Period Beginning: 1/1/20

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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	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number INTEGRITY HC OF GODFREY

0053306

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	(63)	0	0	0	0	0	0	0	0	0	0	(63)	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	2,283	0	0	0	0	0	0	0	0	0	2,283	5
6	Maintenance	0	2,076	0	0	0	0	0	0	0	0	0	2,076	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(63)	4,359	0	0	0	0	0	0	0	0	0	4,296	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	24,168	11,924	0	0	0	0	0	0	0	0	36,092	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	24,168	11,924	0	0	0	0	0	0	0	0	36,092	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(152,273)	0	0	0	0	0	0	0	0	0	(152,273)	19
20	Fees, Subscriptions & Promotions	0	72	0	0	0	0	0	0	0	0	0	72	20
21	Clerical & General Office Expenses	(17,529)	99,089	218	0	0	0	0	0	0	0	0	81,778	21
22	Employee Benefits & Payroll Taxes	0	17,374	25,549	0	0	0	0	0	0	0	0	42,923	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	2,797	0	0	0	0	0	0	0	0	0	2,797	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	571	0	0	0	0	0	0	0	0	0	571	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(17,529)	(32,370)	25,767	0	0	0	0	0	0	0	0	(24,132)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,592)	(3,844)	37,691	0	0	0	0	0	0	0	0	16,255	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number INTEGRITY HC OF GODFREY

0053306

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	(16,408)	0	0	0	0	0	0	0	0	0	0	(16,408)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,454)	0	0	0	0	0	0	0	0	0	0	(1,454)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,812	0	0	0	0	0	0	0	0	0	8,812	34
35	Rent-Equipment & Vehicles	0	941	0	0	0	0	0	0	0	0	0	941	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,862)	9,753	0	0	0	0	0	0	0	0	0	(8,109)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(214,765)	0	0	0	0	0	0	0	0	0	0	(214,765)	43
44	TOTAL Special Cost Centers	(214,765)	0	0	0	0	0	0	0	0	0	0	(214,765)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(250,219)	5,909	37,691	0	0	0	0	0	0	0	0	(206,619)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steven Blisko	60	Integrity HC of Carbonedale	Carbonedale	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 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 Services		\$ 2,283	\$ 2,283	1
2	V	6 Maintenance		Integrity HCC Services		2,076	2,076	2
3	V	10 Nursing and Medical Records		Integrity HCC Services		24,168	24,168	3
4	V	19 Professional Services	198,000	Integrity HCC Services		45,727	(152,273)	4
5	V	20 Dues, Fees, Subscriptions & Promotions		Integrity HCC Services		72	72	5
6	V	21 Clerical & General Office Expenses		Integrity HCC Services		99,089	99,089	6
7	V	22 Employee Benefits & Payroll Taxes		Integrity HCC Services		17,374	17,374	7
8	V	24 Travel and Seminar		Integrity HCC Services		2,797	2,797	8
9	V	26 Insurance-Prop.Liab.Malpractice		Integrity HCC Services		571	571	9
10	V	34 Rent		Integrity HCC Services		8,812	8,812	10
11	V	35 Equipment Lease		Integrity HCC Services		941	941	11
12	V							12
13	V							13
14	Total		\$ 198,000			\$ 203,909	\$ * 5,909	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	\$ 43,558	Integrity Communities Services		\$ 55,482	\$ 11,924	15
16	V	21 Clerical & General Office Expenses				218	218	16
17	V	22 Employee Benefits & Payroll Taxes				25,549	25,549	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		\$ 43,558			\$ 81,249	\$ * 37,691	39

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

Facility Name & ID Number

INTEGRITY HC OF GODFREY

0053306

Report Period Beginning:

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 Columbia	Columbia				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 GODFREY # 0053306 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 GODFREY

0053306

Report Period Beginning:

1/1/20

Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

INTEGRITY HC OF GODFREY

0053306

Report Period Beginning:

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			
	A. Directly Facility Related																	
	Long-Term																	
1							\$	\$				\$						
2																		
3																		
4																		
5																		
	Working Capital																	
6																		
7																		
8																		
9	TOTAL Facility Related						\$	\$				\$						
	B. Non-Facility Related*																	
10																		
11																		
12																		
13																		
14	TOTAL Non-Facility Related						\$	\$				\$						
15	TOTALS (line 9+line14)						\$	\$				\$						

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.		\$	3,407	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	34,585	2
3. Under or (over) accrual (line 2 minus line 1).		\$	31,178	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	7,790	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	38,968	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	30,903	8
	2016	31,671	9
	2017	32,603	10
	2018	34,073	11
	2019	34,585	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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 GODFREY COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0053306

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>24-2-01-33-02-204-038</u>	<u>Long Term Care Property</u>	\$ <u>34,585.12</u>	\$ <u>34,585.12</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>34,585.12</u></u>	\$ <u><u>34,585.12</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 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: 21,330 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

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
	Improvement Type**									
9	New Roof		2015	34,597	887	39	887		4,877	9
10	Signage		2015	2,625	67	39	67		352	10
11	Kitchen Exhaust Fan		2015	4,048	104	39	104		546	11
12										12
13	Replace front doors of facility		2016	6,232	160	39	160		713	13
14	Fix water damage to main level crawl space		2016	4,236	109	39	109		485	14
15	Install new lockson new front doors		2016	2,609	67	39	67		299	15
16	Replace 25 ' of sewer pipe in basement		2016	2,840	73	39	73		325	16
17	New Fire Alarm Installed		2016	16,857	432	39	432		1,926	17
18										18
19	Electrical and lighting work and wallcovering in main lobby									19
20	and prep walls, winstall wallcovering, paint ceiling beams,									20
21	pipes, wire covers, doorframes and shopfront		2017	46,821	1,201	39	1,201		4,201	21
22	New Water heater		2017	3,515	90	39	90		315	22
23										23
24	Wiring for wireless connection for PCC		2018	1,160	30	39	30		74	24
25	Installation of 11 new skylights		2018	9,942	255	39	255		637	25
26										26
27	Repair & Paint Damaged Walls		2019	3,000	77	39	77		115	27
28	Flat light Panel		2019	3,003	77	39	77		116	28
29	Cove Base Repairs		2019	3,500	90	39	90		135	29
30	Rebuilding Washers		2019	6,422	165	39	165		247	30
31	New Range		2019	1,450	37	39	37		56	31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 152,857	\$ 3,919		\$ 3,919	\$	\$ 15,418	70

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

Facility Name & ID Number INTEGRITY HC OF GODFREY

0053306

Report Period Beginning:

1/1/20

Ending:

12/31/20

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	\$ 78,316	\$ 13,254	\$ 15,663	\$ 2,409	5	\$ 57,964	71
72	Current Year Purchases	20,908	20,908	2,091	(18,817)	5	20,908	72
73	Fully Depreciated Assets	39,503				5	39,503	73
74								74
75	TOTALS	\$ 138,727	\$ 34,162	\$ 17,754	\$ (16,408)		\$ 118,375	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 291,584	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 38,081	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,673	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,408)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 133,793	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 1623 West Delmar Avenue LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		68	11/24/14	\$	20	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		68		\$			7

10. Effective dates of current rental agreement:

Beginning 11/24/14

Ending 11/24/34

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

Fiscal Year Ending Annual Rent

12.	<u>/2021</u>	\$ <u>252,214</u>
13.	<u>/2022</u>	\$ <u>262,403</u>
14.	<u>/2023</u>	\$ <u>270,275</u>

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

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

N/A

N/A

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

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10a-3	hrs		\$	1,707	\$ 128,779	\$	1,707	\$	128,779					1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			177	22,770		177		22,770					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs			1,645	123,943		1,645		123,943					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							112,287					112,287	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								3,015					3,015	12
13	Other (specify): <u>Lab</u>	39-2								4,790					4,790	13
14	TOTAL				\$	3,528	\$ 275,492	\$	3,528	\$	120,092	\$	3,528	\$	395,584	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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 43,294	\$ 43,294	1
2	Cash-Patient Deposits	1,919,747	1,919,747	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,204	60,204	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	231,112	231,112	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,254,357	\$ 2,254,357	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	152,857	152,857	15
16	Equipment, at Historical Cost	138,728	138,728	16
17	Accumulated Depreciation (book methods)	(133,794)	(133,794)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 157,791	\$ 157,791	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,412,148	\$ 2,412,148	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 487,668	\$ 487,668	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,406	350,406	29
30	Accrued Salaries Payable	96,324	96,324	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
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 934,398	\$ 934,398	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 934,398	\$ 934,398	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,477,750	\$ 1,477,750	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,412,148	\$ 2,412,148	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,231,786	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,231,786	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	245,968	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 245,968	17
	B. Transfers (Itemize):		
18	Rounding	(4)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (4)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,477,750	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,872,922	1
2	Discounts and Allowances for all Levels	(70,555)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,802,367	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	93,934	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 93,934	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	481,323	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	(30)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	236	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 481,529	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,454	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,454	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending Income</u>	118	28
28a	<u>Misc Income</u>	11	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 129	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,379,413	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	609,150	31
32	Health Care	1,871,772	32
33	General Administration	853,295	33
B. Capital Expense			
34	Ownership	338,369	34
C. Ancillary Expense			
35	Special Cost Centers	460,859	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,133,445	40
41	Income before Income Taxes (line 30 minus line 40)**	245,968	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 245,968	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,108,162	44
45	Private Pay - Net Inpatient Revenue	274,515	45
46	Medicare - Net Inpatient Revenue	998,403	46
47	Other-(specify) <u>Net Patient Revenue</u>	421,287	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,802,367	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 GODFREY

0053306

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	1,886	1,965	\$ 66,030	\$ 33.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,757	2,786	203,871	73.18	3
4	Licensed Practical Nurses	14,998	15,672	364,201	23.24	4
5	CNAs & Orderlies	21,225	21,716	392,519	18.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,790	5,188	62,104	11.97	10
11	Social Service Workers			22,686		11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,182	12,751	158,453	12.43	15
16	Dishwashers					16
17	Maintenance Workers	762	769	36,964	48.07	17
18	Housekeepers	6,663	6,838	122,381	17.90	18
19	Laundry	2,684	2,744	25,667	9.35	19
20	Administrator	2,080	2,080	66,617	32.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,469	2,597	33,531	12.91	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	2,450	2,655	98,813	37.22	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS</u>	3,089	3,251	106,165	32.66	33
34	TOTAL (lines 1 - 33)	78,035	81,012	\$ 1,760,002 *	\$ 21.73	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	\$ 4,054	1-3	35
36	Medical Director	Monthly	22,323	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	32,652	10-3	38
39	Pharmacist Consultant	Monthly	5,076	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	5,330	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	15,938	21-3	48
49	TOTAL (lines 35 - 48)		\$ 119,977		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	
LISZEWSKI, KATHRYN	Administrator	0	\$ 48,649	Workers' Compensation Insurance	\$ 44,007	IDPH License Fee	\$ 3,860	
McKinnon, Lori L.	Administrator	0	17,968	Unemployment Compensation Insurance	15,072	Advertising: Employee Recruitment		
				FICA Taxes	172,063	Health Care Worker Background Check		
				Employee Health Insurance	54,660	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Allscripts	1,175	
				Employee Other Benefits	5,769	HCCI	4,200	
						Clia Laboratory	180	
						Secretary of State	302	
						Other Fees	1,876	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 66,617			Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,593	
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		\$ 1770			\$	Out-of-State Travel	\$
Johnson, Goldberg, & Brown	Accounting Fees		3000					
GGM Associates Inc	Accounting Fees		6000					
Integrity HCC	Management Fees		214,500				In-State Travel	
BANK LEUMI	Legal Fees		936				AUTO ALLOWANCE	3,132
Integrity HCC	Professional fees		354				Mileage Reimbursement	670
Sandberg Phoenix & Von Gontard P.	Collection Costs		(0)				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)			\$ 226,560				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,802

* Attach copy of IMRF notifications

**See instructions.

