		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0050997

Facility Name: INTEGRITY HC OF MARION

Address: 1301 East Deyoung (Number) Marion (City) 62959 (Zip Code)

County: Williamson

Telephone Number: 708-426-2315 **Fax #** 708-426-2415

HFS ID Number:

Date of Initial License for Current Owners: 06/01/10

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Aaron Mauer **Telephone Number:** 773-747-4506
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) 5/28/2021 (Date)
(Type or Print Name) Alan Irni
(Title) CFO

Paid Preparer

(Signed) 5/27/2021 (Date)
(Print Name and Title) Aaron Mauer, President
(Firm Name & Address) GGM Associates, Inc., 6101 Nimtz Parkway South Bend IN 46628
(Telephone) 773-747-4506 Fax # 773-747-4725

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	125	Skilled (SNF)	125	45,750	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	125	TOTALS	125	45,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	22,247	1,624	5,741	29,612	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,247	1,624	5,741	29,612	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.73%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

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

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

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

I. On what date did you start providing long term care at this location?
Date started 06/01/10

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 125 and days of care provided 5,100

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 MARION # 0050997 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	175,488	20,076	11,101	206,665		206,665	(44)	206,621			1
2	Food Purchase		182,843		182,843		182,843		182,843			2
3	Housekeeping	155,282	15,966		171,248		171,248		171,248			3
4	Laundry	61,154	8,420		69,574		69,574		69,574			4
5	Heat and Other Utilities			113,704	113,704		113,704	2,975	116,679			5
6	Maintenance	63,988	16,582	18,256	98,826		98,826	2,704	101,530			6
7	Other (specify):*											7
8	**TOTAL General Services**	455,912	243,887	143,061	842,860		842,860	5,636	848,496			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,682,211	250,649	49,406	1,982,266		1,982,266	43,017	2,025,283			10
10a	Therapy			614,159	614,159		614,159		614,159			10a
11	Activities	57,201	3,919		61,120		61,120		61,120			11
12	Social Services	36,214		5,378	41,592		41,592		41,592			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			9,018	9,018		9,018		9,018			15
16	**TOTAL Health Care and Programs**	1,775,626	254,568	677,961	2,708,155		2,708,155	43,017	2,751,172			16
	C. General Administration											
17	Administrative	82,834			82,834		82,834		82,834			17
18	Directors Fees											18
19	Professional Services			292,252	292,252		292,252	(198,416)	93,836			19
20	Dues, Fees, Subscriptions & Promotions			13,140	13,140		13,140	94	13,234			20
21	Clerical & General Office Expenses	66,196	26,761	98,650	191,607		191,607	112,901	304,508			21
22	Employee Benefits & Payroll Taxes			293,187	293,187		293,187	47,335	340,522			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,330	4,330		4,330	3,644	7,974			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			271,287	271,287		271,287	744	272,031			26
27	Other (specify):*											27
28	**TOTAL General Administration**	149,030	26,761	972,846	1,148,637		1,148,637	(33,696)	1,114,941			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,380,568	525,216	1,793,868	4,699,652		4,699,652	14,957	4,714,609			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 MARION #0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			106,619	106,619		106,619	(41,212)	65,407			30
31	Amortization of Pre-Op. & Org.			815	815		815		815			31
32	Interest			35,159	35,159		35,159	(120)	35,039			32
33	Real Estate Taxes			62,461	62,461		62,461		62,461			33
34	Rent-Facility & Grounds			910,190	910,190		910,190	11,482	921,672			34
35	Rent-Equipment & Vehicles							1,226	1,226			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,115,244	1,115,244		1,115,244	(28,624)	1,086,620			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			133	133		133		133			38
39	Ancillary Service Centers		202,272		202,272		202,272		202,272			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			227,098	227,098		227,098		227,098			42
43	Other (specify):* **Bad Debt Expense**			116,505	116,505		116,505	(116,505)				43
44	**TOTAL Special Cost Centers**		202,272	343,736	546,008		546,008	(116,505)	429,503			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,380,568	727,488	3,252,848	6,360,904		6,360,904	(130,172)	6,230,732			45

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(41,212)	30		9
10	Interest and Other Investment Income	(120)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(44)	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	(705)	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	(116,505)	43		24
25	Fund Raising, Advertising and Promotional	(15,720)	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)**	$ (174,306)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 44,134	Various	36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (130,172)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		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

INTEGRITY HC OF MARION

ID# 0050997

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	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(44)	0	0	0	0	0	0	0	0	0	0	(44)	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	**TOTAL General Services**	(44)	5,680	0	0	0	0	0	0	0	0	0	5,636	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	31,491	11,526	0	0	0	0	0	0	0	0	43,017	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	31,491	11,526	0	0	0	0	0	0	0	0	43,017	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	(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	(16,425)	129,115	211	0	0	0	0	0	0	0	0	112,901	21
22	Employee Benefits & Payroll Taxes	0	22,638	24,697	0	0	0	0	0	0	0	0	47,335	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	**TOTAL General Administration**	(16,425)	(42,179)	24,908	0	0	0	0	0	0	0	0	(33,696)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,469)	(5,008)	36,434	0	0	0	0	0	0	0	0	14,957	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 **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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(41,212)	0	0	0	0	0	0	0	0	0	0	(41,212)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(120)	0	0	0	0	0	0	0	0	0	0	(120)	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	**TOTAL Ownership**	(41,332)	12,708	0	0	0	0	0	0	0	0	0	(28,624)	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):*	(116,505)	0	0	0	0	0	0	0	0	0	0	(116,505)	43
44	**TOTAL Special Cost Centers**	(116,505)	0	0	0	0	0	0	0	0	0	0	(116,505)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(174,306)	7,700	36,434	0	0	0	0	0	0	0	0	(130,172)	45

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 Serivce	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 Godfrey	Godfrey			
		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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	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.

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 42,106	Integrity Communities Services		$ 53,632	$ 11,526	15
16	V	21	Clerical & General Office Expenses		Integrity Communities Services		211	211	16
17	V	22	Employee Benefits & Payroll Taxes		Integrity Communities Services		24,697	24,697	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			$ 42,106			$ 78,540	$ * 36,434	39

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 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			Integrity HC of Herrin	Herrin				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 MARION # 0050997 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column 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 MARION # 0050997 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 [X]

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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.)**

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 61,864	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.)		$ 57,826	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,038)	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.)		$ 66,499	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.		$ 62,461	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	58,609	8
	2016	58,983	9
	2017	60,490	10
	2018	61,585	11
	2019	61,585	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:

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 MARION COUNTY Williamson

FACILITY IDPH LICENSE NUMBER 0050997

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-17-151-001	Long Term Care Property	$ 57,826.08	$ 57,826.08
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 57,826.08	$ 57,826.08

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.

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,500 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

1. Total Amount Incurred: 12,225 2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 815 4. Dates Incurred: Prior to 06/01/10

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Windows and Doors			2010	5,700	146	39	146		1,545	9
10	Humidifier - not used for capital rate increase			2010	676	17	39	17		181	10
11	Heat and cool system - not used for capital rate increase			2010	2,434	62	39	62		657	11
12	Heating system - not used for capital rate increase			2010	5,949	153	39	153		1,618	12
13	Heating system - not used for capital rate increase			2010	1,082	28	39	28		295	13
14	Fire Sprinklers			2011	10,018	257	39	257		2,548	14
15	Fire Sprinklers			2011	75,795	1,943	39	1,943		18,460	15
16	Roof Repairs			2011	9,750	250	39	250		2,417	16
17	Panelling			2011	9,398	241	39	241		2,269	17
18	Exterior work, columns, access panel, sconces, soffit			2011	30,000	769	39	769		7,306	18
19	Lobby: demolition, Lighting / Electrical, Painting, Flooring										19
20	Trim, Millwork			2011	101,615	2,606	39	2,606		24,755	20
21	Wall covering and ceiling tiles in admission office			2011	7,735	198	39	198		1,882	21
22	Nurses Station: wallpaper, reface desk, lighting, painting			2011	21,087	541	39	541		5,138	22
23	Flooring and Painting Vestibule			2011	5,687	146	39	146		1,387	23
24	Lighting, wallpaper, floor tile, kitchen cabinets for dining			2011	31,194	800	39	800		7,600	24
25	Additional parking spots / asphalt			2011	61,666	1,581	39	1,581		15,020	25
26	Rewire failing door closures			2011	3,800	97	39	97		923	26
27	Refinish doors			2011	16,500	423	39	423		4,019	27
28	New ceiling tiles and basket lighting fixtures			2011	16,000	410	39	410		3,896	28
29	New windows and glass door			2011	27,000	692	39	692		6,575	29
30	Install EIFS and paint			2011	68,000	1,744	39	1,744		16,567	30
31	Custom exterior sign			2011	19,000	487	39	487		4,627	31
32	PTAC units			2011	38,000	974	39	974		9,254	32
33	New kitchen tile			2011	10,800	277	39	277		2,631	33
34	Steel Valve			2011	2,300	59	39	59		560	34
35	Hot water boilers repair			2011	2,000	51	39	51		486	35
36	Roof Enginnering fees			2011	4,500	115	39	115		1,094	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Resident rooms: door handles, ceiling tiles, paint, flooring,	2011	$	$		$	$	$	37
38	lighting fixtures	2011	138,348	3,547	39	3,547		33,697	38
39	Corridors: handrails, signs, doors, ceiling tiles, lighting	2011	130,900	3,356	39	3,356		31,883	39
40	Windows and painting of laundry room	2011	3,300	85	39	85		806	40
41	HVACs	2011	32,400	831	39	831		7,894	41
42	Landscaping	2011	12,500	321	39	321		3,048	42
43	Drainage	2011	4,600	118	39	118		1,121	43
44	Custom laminate nurses station	2011	16,900	433	39	433		4,115	44
45	Restrooms: molding, chair rail, door, tile, paint, toliets, mirror	2011	22,000	564	39	564		5,358	45
46	Whirlpool Tub, plumbing, wall tiles	2011	12,000	308	39	308		2,925	46
47	Shower room: door, tile, paint, shower stalls, bathtub, lights	2011	55,000	1,410	39	1,410		13,396	47
48	Patio: concrete, doors, drainage	2011	41,600	1,067	39	1,067		10,135	48
49	Dining: molding, chair rail, ceiling tiles, wallcovering, signs	2011	50,535	1,296	39	1,296		12,312	49
50	New doors and walls in medicine storage room	2011	6,000	154	39	154		1,463	50
51	Storage room: new wall, door and paint	2011	5,500	141	39	141		1,340	51
52	Toliets, sinks, mirrors, lighting grab bars in residents bathrooms	2011	30,000	769	39	769		7,306	52
53	Roof	2011	83,000	2,128	39	2,128		20,216	53
54	Toliets, sinks, mirrors, lighting grab bars in residents bathrooms	2011	10,000	256	39	256		2,433	54
55	Call bell system and wander management system	2011	61,000	1,564	39	1,564		14,858	55
56	Med room and MOP: closet door, sink, counter, lighting, paint	2011	5,700	146	39	146		1,387	56
57	Bathroom: flooring, sink, toliet, lighting, grab bars, paint	2011	4,100	105	39	105		998	57
58	Concrete patio	2011	6,300	162	39	162		1,538	58
59	Sink room: tile, backsplash, paint, countertops, cabinets	2011	4,000	103	39	103		977	59
60	Woodlock kick plates	2011	7,900	203	39	203		1,927	60
61	Refinish nurse station, quartz countertop	2011	5,300	136	39	136		1,292	61
62	Flooring for vestibule	2011	2,300	59	39	59		560	62
63	Seating areas: door, paint, lighting, ceiling tile, drywall, flooring	2011	8,100	208	39	208		1,975	63
64	Water heater and installation	2013	2,836	73	39	73		558	64
65	Wiring for nurse stations and kiosks	2013	20,763	532	39	532		3,902	65
66									66
67	5 ton gas electric rooftop units	2014	10,768	53	39	53		10,768	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,381,336	$ 35,196		$ 35,196	$	$ 343,898	70

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,381,336	$ 35,196		$ 35,196	$	$ 343,898	1
2									2
3	Install new Duro-last roofing system	2015	148,950	3,819	39	3,819		20,845	3
4	Build 30 x 40 x 8ft metal barn	2015	15,500	397	39	397		2,169	4
5	309 sq yrds of hot-mix asphalt and pouring	2015	6,475	166	39	166		906	5
6	Repair damage to roof	2015	1,383	35	39	35		193	6
7	Troubleshoot and fix wonderguard call bell system	2015	1,575	40	39	40		221	7
8	Repair kitchen drain line, tie in new drains, pour concrete	2015	23,800	610	39	610		3,332	8
9	Labor, parts, excavating, disposal fees to repair water line	2015	3,566	91	39	91		499	9
10									10
11									11
12									12
13									13
14	Install 7 rooms nurse call system	2016	2,164	55	39	55		246	14
15	Gas / electric 4 ton rooftop	2016	5,959	153	39	153		682	15
16	Redo rear parking lot (fix sinkhole)	2016	2,100	54	39	54		241	16
17									17
18	New mixing valve	2017	7,724	198	39	198		693	18
19	New HVAC	2017	8,282	212	39	212		743	19
20	New compressor	2017	3,600	92	39	92		323	20
21									21
22	Replace parking lot lighting	2018	2,195	56	39	56		141	22
23	Remove and replace plumbing and a section of floor tile	2018	6,568	168	39	168		421	23
24	Designed, manufacture and install new awning	2018	2,409	62	39	62		169	24
25					39				25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,623,586	$ 41,407		$ 41,407	$	$ 375,719	34

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 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	$ 94,163	$ 13,536	$ 18,833	$ 5,297	5	$ 84,530	71
72	Current Year Purchases	51,676	51,676	5,168	(46,508)	5	51,676	72
73	Fully Depreciated Assets	369,758				5	369,758	73
74								74
75	TOTALS	$ 515,597	$ 65,212	$ 24,000	$ (41,212)		$ 505,964	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)	$ 2,139,183	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 106,619	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,408	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (41,212)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 881,683	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Illinois Healthcare Properties, 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:	1995	68	05/15/10	$	20	N/A	3
4	Additions	2001	57					4
5								5
6								6
7	TOTAL		125		$ **			7

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

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

10. Effective dates of current rental agreement:
Beginning 06/26/14
Ending 05/31/34

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

	Fiscal Year Ending	Annual Rent
12.	12/2021	$ 920,134
13.	12/2022	$ 938,536
14.	/2023	$ 966,692

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ N/A Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

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

3. CLINICAL PORTION:

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	4,842	$ 260,566	$	4,842	$ 260,566	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,631	119,744		1,631	119,744	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		4,029	233,849		4,029	233,849	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				202,272		202,272	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					4,447		4,447	12
13	Other (specify): Lab	39-2					15,569		15,569	13
14	TOTAL			$	10,502	$ 614,159	$ 222,288	10,502	$ 836,447	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 487,473	$ 487,473	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,931,782	2,931,782	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	279,675	279,675	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,698,930	$ 3,698,930	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	1,613,922	1,613,922	15
16	Equipment, at Historical Cost	528,263	528,263	16
17	Accumulated Depreciation (book methods)	(883,666)	(883,666)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(8,625)	(8,625)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,262,119	$ 1,262,119	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,961,049	$ 4,961,049	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,040,682	$ 1,040,682	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	455,518	455,518	29
30	Accrued Salaries Payable	182,647	182,647	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)**	$ 1,678,847	$ 1,678,847	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)**	$ 1,678,847	$ 1,678,847	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,282,202	$ 3,282,202	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,961,049	$ 4,961,049	48

***(See instructions.)**

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,097,666	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,097,666	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,184,540	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)**	$ 2,184,540	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)**	$ 3,282,202	24 *

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,896,037	1
2	Discounts and Allowances for all Levels	(165,937)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,730,100	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	273,861	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 273,861	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,540,474	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	158	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	(667)	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,539,965	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	120	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 120	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Income	1,398	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,398	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,545,444	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	842,860	31
32	Health Care	2,708,155	32
33	General Administration	1,148,637	33
	B. Capital Expense		
34	Ownership	1,115,244	34
	C. Ancillary Expense		
35	Special Cost Centers	546,008	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)***	$ 6,360,904	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,184,540	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,184,540	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,800,907	44
45	Private Pay - Net Inpatient Revenue	172,880	45
46	Medicare - Net Inpatient Revenue	2,465,939	46
47	Other-(specify) Net Patient Revenue	290,374	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,730,100	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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,194	2,268	$ 61,316	$ 27.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,025	6,245	249,941	40.02	3
4	Licensed Practical Nurses	21,142	21,868	563,801	25.78	4
5	CNAs & Orderlies	35,570	36,819	575,387	15.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,000	5,244	57,201	10.91	10
11	Social Service Workers	2,574	2,701	36,214	13.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,823	14,550	175,488	12.06	15
16	Dishwashers					16
17	Maintenance Workers	2,263	2,429	63,988	26.34	17
18	Housekeepers	12,996	13,373	155,282	11.61	18
19	Laundry	4,471	4,578	61,154	13.36	19
20	Administrator	1,885	2,026	82,834	40.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,700	1,750	66,196	37.83	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	2,109	2,221	84,533	38.06	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	2,149	2,275	147,233	64.72	33
34	TOTAL (lines 1 - 33)	113,901	118,347	$ 2,380,568 *	$ 20.12	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,101	1-3	35
36	Medical Director	Monthly		9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	33,352	10-3	38
39	Pharmacist Consultant	Monthly	9,018	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	5,378	12-3	45
46	Other(specify) MDS	Monthly	16,054	10-3	46
47	HR Corp Compliance	Monthly	18,550	21-3	47
48	MARKETING CONSULTANT	Monthly	15,550	21-3	48
49	TOTAL (lines 35 - 48)		$ 109,003		49

C. CONTRACT NURSES

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

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 Report Period Beginning: 1/1/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melia, Tina J.	Administrator	0	$ 82,834
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,834

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Integrity HCC	Management Fees	$ 258,000
Bradley & Associates	Accounting Fees	616
GGM Associates Inc	Accounting Fees	6,000
Johnson, Goldberg, & Brown	Accounting Fees	3,000
BANK LEUMI	Legal Fees	7,068
Mts Consulting	Professional Fees	(1,131)
Sandberg Phoenix & Von Gontard P.	Collection Costs	18,635
MARKOFF LAW LLC	Collection Costs	64
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 292,252

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,972
Unemployment Compensation Insurance	28,296
FICA Taxes	222,216
Employee Health Insurance	35,108
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Other Benefits	4,930
TOTAL (agree to Schedule V, line 22, col.8)	$ 340,522

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,316
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Franklin williamson Health dept	200
HCCI	4,200
Prospect Resources	300
Clia Laboratory	180
Other fees	5,038
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,234

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
AUTO ALLOWANCE	4,658
Mileage Reimbursement	2,332
Seminar Expense	
EDUCATION	985
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,974

**See instructions.

Facility Name & ID Number INTEGRITY HC OF MARION # 0050997 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. $ **14,655** 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. $ **227,098**
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? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.