

		FOR BHF USE					

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

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

<p>I. IDPH License ID Number: <u>0053298</u></p> <p>Facility Name: <u>INTEGRITY HC OF SMITHTON</u></p> <p>Address: <u>107 South Lincoln</u> <u>Smithton</u> <u>62285</u> <small>Number City Zip Code</small></p> <p>County: <u>St Clair</u></p> <p>Telephone Number: <u>708-426-2315</u> Fax # <u>708-426-2415</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>11/24/14</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Aaron Mauer</u> Telephone Number: <u>773-747-4506</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ <u>5/28/2021</u> <small>(Date)</small> (Type or Print Name) <u>Alan Irni</u> (Title) <u>CFO</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ <u>5/27/2021</u> <small>(Date)</small> (Print Name and Title) <u>Aaron Mauer</u> <u>President</u> (Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtzy Parkway South Bend IN 46628</u> (Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u> </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ <u>5/28/2021</u> <small>(Date)</small> (Type or Print Name) <u>Alan Irni</u> (Title) <u>CFO</u>	Paid Preparer	(Signed) _____ <u>5/27/2021</u> <small>(Date)</small> (Print Name and Title) <u>Aaron Mauer</u> <u>President</u> (Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtzy Parkway South Bend IN 46628</u> (Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ <u>5/28/2021</u> <small>(Date)</small> (Type or Print Name) <u>Alan Irni</u> (Title) <u>CFO</u>							
Paid Preparer	(Signed) _____ <u>5/27/2021</u> <small>(Date)</small> (Print Name and Title) <u>Aaron Mauer</u> <u>President</u> (Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimtzy Parkway South Bend IN 46628</u> (Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u>							

Facility Name & ID Number INTEGRITY HC OF SMITHTON

0053298 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	41	Skilled (SNF)	41	15,006	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,960	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,966	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,745	1,047	2,581	9,373	8
9	SNF/PED					9
10	ICF	8,407	1,531	230	10,168	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,152	2,578	2,811	19,541	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.86%

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 41 and days of care provided 2,424

Medicare Intermediary N/A

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 SMITHTON # 0053298 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	197,809	10,806	6,907	215,522		215,522	(79)	215,443		1
2	Food Purchase		130,410		130,410		130,410		130,410		2
3	Housekeeping	88,589	10,321		98,910		98,910		98,910		3
4	Laundry	37,819	7,712		45,531		45,531		45,531		4
5	Heat and Other Utilities			88,784	88,784		88,784	2,283	91,067		5
6	Maintenance	47,730	30,457	27,051	105,238		105,238	2,076	107,314		6
7	Other (specify):*										7
8	TOTAL General Services	371,947	189,706	122,742	684,395		684,395	4,280	688,675		8
	B. Health Care and Programs										
9	Medical Director			15,823	15,823		15,823		15,823		9
10	Nursing and Medical Records	1,159,162	150,666	49,415	1,359,243		1,359,243	49,869	1,409,112		10
10a	Therapy			376,535	376,535		376,535		376,535		10a
11	Activities	67,570	2,847		70,417		70,417		70,417		11
12	Social Services	36,759		5,973	42,732		42,732		42,732		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* RX Consultant			5,886	5,886		5,886		5,886		15
16	TOTAL Health Care and Programs	1,263,491	153,513	453,632	1,870,636		1,870,636	49,869	1,920,505		16
	C. General Administration										
17	Administrative	72,800			72,800		72,800		72,800		17
18	Directors Fees										18
19	Professional Services			211,161	211,161		211,161	(152,273)	58,888		19
20	Dues, Fees, Subscriptions & Promotions			7,815	7,815		7,815	72	7,887		20
21	Clerical & General Office Expenses	32,347	17,353	289,467	339,167		339,167	(108,455)	230,712		21
22	Employee Benefits & Payroll Taxes			227,097	227,097		227,097	72,446	299,543		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,019	1,019		1,019	2,797	3,816		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			171,002	171,002		171,002	571	171,573		26
27	Other (specify):*										27
28	TOTAL General Administration	105,147	17,353	907,561	1,030,061		1,030,061	(184,842)	845,219		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,740,585	360,572	1,483,935	3,585,092		3,585,092	(130,694)	3,454,398		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 SMITHTON

#0053298

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			33,224	33,224		33,224	(16,131)	17,093			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,370	16,370		16,370	(31)	16,339			32
33	Real Estate Taxes			52,896	52,896		52,896		52,896			33
34	Rent-Facility & Grounds			215,167	215,167		215,167	8,812	223,979			34
35	Rent-Equipment & Vehicles							941	941			35
36	Other (specify):*											36
37	TOTAL Ownership			317,657	317,657		317,657	(6,409)	311,248			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			(134)	(134)		(134)		(134)			38
39	Ancillary Service Centers		46,421		46,421		46,421		46,421			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,645	198,645		198,645		198,645			42
43	Other (specify):* Bad Debt Expense			18,477	18,477		18,477	(18,477)				43
44	TOTAL Special Cost Centers		46,421	216,988	263,409		263,409	(18,477)	244,932			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,740,585	406,993	2,018,580	4,166,158		4,166,158	(155,580)	4,010,578			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	(16,131)	30		9
10	Interest and Other Investment Income	(31)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(79)	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	(193,251)	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	(18,477)	43		24
25	Fund Raising, Advertising and Promotional	(14,764)	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)	\$ (242,733)		\$	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)	\$ 87,153	Various	36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (155,580)		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# 0053298

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 SMITHTON

0053298

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	(79)	0	0	0	0	0	0	0	0	0	0	(79)	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	(79)	4,359	0	0	0	0	0	0	0	0	0	4,280	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	25,701	0	0	0	0	0	0	0	0	49,869	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	25,701	0	0	0	0	0	0	0	0	49,869	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	(208,015)	99,089	471	0	0	0	0	0	0	0	0	(108,455)	21
22	Employee Benefits & Payroll Taxes	0	17,374	55,072	0	0	0	0	0	0	0	0	72,446	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	(208,015)	(32,370)	55,543	0	0	0	0	0	0	0	0	(184,842)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(208,094)	(3,844)	81,244	0	0	0	0	0	0	0	0	(130,694)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number INTEGRITY HC OF SMITHTON

0053298

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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(16,131)	0	0	0	0	0	0	0	0	0	0	(16,131)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31)	0	0	0	0	0	0	0	0	0	0	(31)	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	(16,162)	9,753	0	0	0	0	0	0	0	0	0	(6,409)	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):*	(18,477)	0	0	0	0	0	0	0	0	0	0	(18,477)	43
44	TOTAL Special Cost Centers	(18,477)	0	0	0	0	0	0	0	0	0	0	(18,477)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(242,733)	5,909	81,244	0	0	0	0	0	0	0	0	(155,580)	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 Godfrey	Godfrey			
		Integrity HC of Anna	Anna			
		Integrity HC of Marion	Marion			

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	\$ 93,891			\$ 119,592	\$ 25,701	15
16	V	21 Clerical & General Office Expenses				471	471	16
17	V	22 Employee Benefits & Payroll Taxes				55,072	55,072	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		\$ 93,891			\$ 175,135	\$ * 81,244	39

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

Facility Name & ID Number

INTEGRITY HC OF SMITHTON

0053298

Report Period Beginning:

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 SMITHTON # 0053298 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 SMITHTON

0053298

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1																				
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.		\$	3,925	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.)		\$	48,218	2
3. Under or (over) accrual (line 2 minus line 1).		\$	44,293	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.)		\$	8,603	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.		\$	52,895	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2015	33,430	8
	2016	35,745	9
	2017	44,975	10
	2018	46,164	11
	2019	48,218	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 SMITHTON COUNTY St Clair

FACILITY IDPH LICENSE NUMBER 0053298

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>13-33.0-113-004</u>	<u>Long Term Care Property</u>	\$ <u>48,217.62</u>	\$ <u>48,217.62</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>48,217.62</u></u>	\$ <u><u>48,217.62</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,919 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: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for counts. Row 1: 1, 2, 3, \$, 1. Row 2: 2, 2. Row 3: 3 TOTALS, \$, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Door with push paddle & standard lock cylinder		2015	3,565	91	39	91		502
10									
11	Becker Floor Covering - new kitchen floor		2016	4,349	112	39	112		498
12	Marmic Fire & Safety Co. Inc. - install fire alarm panel		2016	16,318	418	39	418		1,865
13	Direct Supply, Inc - new heater installation		2016	1,508	39	39	39		173
14									
15	New condensing unit		2017	2,164	55	39	55		195
16	Delayed egress, install		2017	4,800	123	39	123		430
17									
18	Murals in Large cafeteria, TV room and Large hall		2018	38,420	985	39	985		2,463
19	Wiring for Mesh A60 PCC		2018	1,160	30	39	30		74
20	Replacement of micro switch on front door crash bar		2018	3,841	98	39	98		246
21	Furnish and install conduit and wire to restore power to rooms								
22	312, 314, 315 and 317		2018	6,995	159	39	159		409
23	Removal and replacement of existing water heater		2018	1,550	40	39	40		99
24	Repair dining room ceiling		2018	1,750	45	39	45		112
25	Wall A/C unit replacement		2018	759	19	39	19		49
26									
27	Residential Hallways Cove Base		2019	4,750	122	39	51	(71)	183
28	Shower Room Remodeling		2019	2,150	55	39	14	(41)	83
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

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)	\$	\$		\$	\$	\$	70
			94,079		2,392	2,279	(112)	7,381

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 63,913	\$ 10,532	\$ 12,783	\$ 2,251	5	\$ 51,843	71
72	Current Year Purchases	20,299	20,299	2,030	(18,269)	5	20,299	72
73	Fully Depreciated Assets	34,119				5	34,119	73
74								74
75	TOTALS	\$ 118,331	\$ 30,831	\$ 14,813	\$ (16,019)		\$ 106,261	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)	\$ 212,410	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 33,223	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,092	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (16,131)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 113,642	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: 107 South Lincoln, LLC

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>101</u>	<u>11/24/14</u>	\$	<u>20</u>	<u>N/A</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		101		\$			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>12/2021</u>	\$ <u>221,464</u>
13.	<u>12/2022</u>	\$ <u>225,893</u>
14.	<u>12/2023</u>	\$ <u>232,670</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

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		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$	2,383	\$ 142,481				2,383	\$ 142,481					1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,615	106,530				1,615	106,530					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs		2,510	127,524				2,510	127,524					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							46,421					46,421	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								2,962					2,962	12
13	Other (specify): <u>Lab</u>	39-2								3,587					3,587	13
14	TOTAL			\$	6,508	\$ 376,535				\$ 52,970			6,508	\$ 429,505		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	\$ 537,337	\$ 537,337	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	842,016	842,016	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):	133,616	133,616	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,512,969	\$ 1,512,969	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	94,079	94,079	15
16	Equipment, at Historical Cost	118,332	118,332	16
17	Accumulated Depreciation (book methods)	(113,633)	(113,633)	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)	\$ 98,778	\$ 98,778	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,611,747	\$ 1,611,747	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 693,327	\$ 693,327	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	345,747	345,747	29
30	Accrued Salaries Payable	92,346	92,346	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)	\$ 1,131,420	\$ 1,131,420	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)	\$ 1,131,420	\$ 1,131,420	46
47	TOTAL EQUITY(page 18, line 24)	\$ 480,327	\$ 480,327	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,611,747	\$ 1,611,747	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (108,525)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (108,525)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	588,849	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)	\$ 588,849	17
	B. Transfers (Itemize):		
18	Rounding	3	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 3	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 480,327	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number INTEGRITY HC OF SMITHTON

0053298

Report Period Beginning: 1/1/20

Ending: 12/31/20

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

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

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

1

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,553,936	1
2	Discounts and Allowances for all Levels	(116,866)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,437,070	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	288,748	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 288,748	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	1,028,681	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	111	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	169	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,028,961	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	31	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	197	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 197	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,755,007	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	684,395	31
32	Health Care	1,870,636	32
33	General Administration	1,030,061	33
B. Capital Expense			
34	Ownership	317,657	34
C. Ancillary Expense			
35	Special Cost Centers	263,409	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)*	\$ 4,166,158	40
41	Income before Income Taxes (line 30 minus line 40)**	588,849	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 588,849	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,975,211	44
45	Private Pay - Net Inpatient Revenue	364,435	45
46	Medicare - Net Inpatient Revenue	1,034,907	46
47	Other-(specify) Net Patient Revenue	62,517	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,437,070	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 SMITHTON

0053298

Report Period Beginning:

1/1/20

Ending:

12/31/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 85,267	\$ 40.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,671	6,986	248,676	35.60	3
4	Licensed Practical Nurses	4,274	4,398	290,527	66.06	4
5	CNAs & Orderlies	18,312	18,690	463,755	24.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,604	2,711	67,570	24.92	10
11	Social Service Workers	2,090	2,190	36,759	16.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,322	12,687	197,809	15.59	15
16	Dishwashers					16
17	Maintenance Workers	2,708	2,756	47,730	17.32	17
18	Housekeepers	1,569	1,569	88,589	56.46	18
19	Laundry	5,618	5,855	37,819	6.46	19
20	Administrator	2,080	2,080	72,800	35.00	20
21	Assistant Administrator	541	541		0.00	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	371	405	32,347	79.87	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	2,637	2,794	23,548	8.43	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MDS</u>	1,157	1,189	47,388	39.86	33
34	TOTAL (lines 1 - 33)	65,034	66,931	\$ 1,740,584 *	\$ 26.01	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 6,907	1-3	35
36	Medical Director	Monthly	15,823	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	33,352	10-3	38
39	Pharmacist Consultant	Monthly	5,886	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	5,973	12-3	45
46	Other(specify) <u>MDS</u>	Monthly	16,062	10-3	46
47	<u>HR Corp Compliance</u>	Monthly	18,550	21-3	47
48	<u>MARKETING CONSULTANT</u>	Monthly	15,688	21-3	48
49	TOTAL (lines 35 - 48)		\$ 118,242		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	
HOOVER-SHAW, SARA C.	Administrator	0	\$ 72,800	Workers' Compensation Insurance	\$ 45,624	IDPH License Fee	\$ 890	
				Unemployment Compensation Insurance	23,079	Advertising: Employee Recruitment		
				FICA Taxes	195,633	Health Care Worker Background Check		
				Employee Health Insurance	27,228	(Indicate # of checks performed _____)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		St Clair County Health Dept	350	
				Employee Benefits Other	7,979	HCCI	4,200	
						Smithton Chamber of Commerce	75	
						Secretary of State	302	
						Other fees	5,070	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 72,800			Less: Public Relations Expense	()	
(List each licensed administrator separately.)						Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,887	
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
Integrity HCC	Management Fees		\$ 181,500			\$	Out-of-State Travel	\$
Johnson, Goldberg, & Brown	Accounting Fees		3,000					
GGM Associates Inc.	Accounting Fees		478					
Sandberg Phoenix & Von Gontard P.	Collection Costs		6,184				In-State Travel	
Polsinelli PC	Legal Fees		9,865				AUTO ALLOWANCE	2,667
MTS CONSULTING LLC	Professional fees		9,633				Mileage Reimbursement	1,149
Integrity HCC Services LLC	Professional fees		500					
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 211,161	TOTAL		\$	Entertainment Expense	()
(For legal fee disclosure, see page 39 of instructions)							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,816

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number INTEGRITY HC OF SMITHTON

0053298

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? _____
- (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. \$ 12,033 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. \$ 198,645
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 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.