

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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.

I. IDPH License ID Number: <u>0053306</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Integrity HC of Godfrey</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>1623-29 W Delmar Ave</u> <u>Godfrey</u> <u>62035</u>																																																	
Number City Zip Code																																																	
County: <u>Madison</u>																																																	
Telephone Number: <u>(708) 236-0000</u> Fax # <u>(708) 236-0001</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Alan Irni</u></td></tr><tr><td>(Title) <u>CFO</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u></td></tr><tr><td>(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN. 46225</u></td></tr><tr><td>(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Alan Irni</u>	(Title) <u>CFO</u>	(Date) _____	Paid Preparer	(Signed) _____	(Print Name and Title) <u>Daniel S. Gaafar</u> <u>Partner</u>	(Firm Name & Address) <u>Bradley Associates</u> <u>201 S. Capitol Ave., Suite 700, Indianapolis, IN. 46225</u>	(Telephone) <u>(317) 237-5500</u> Fax # <u>(317) 237-5503</u>																																				
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Date of Initial License for Current Owners: <u>11/24/14</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY,NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code _____</td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☒</td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td></td><td></td></tr></table>		☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.					☐	Limited Liability Co.					☐	Trust					☐	Other _____		
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		☐	Limited Liability Co.																																														
		☐	Trust																																														
		☐	Other _____																																														
In the event there are further questions about this report, please contact:		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																																															
Name: <u>Daniel S. Gaafar</u> Telephone Number: <u>317-237-5500</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number

Integrity HC of Godfrey

#

0053306

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	68	Skilled (SNF)	68	24,888	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,888	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,698	3,063	2,472	18,233	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,698	3,063	2,472	18,233	14

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

73.26%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold 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

11/24/14

J. Was the facility purchased or leased after January 1, 1978?

YES

X

Date

11/24/14

NO

K. Was the facility certified for Medicare during the reporting year?

YES

X

NO

If YES, enter number of beds certified

68

and days of care provided

2,404

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:

12/31/16

Fiscal Year:

12/31/16

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

Facility Name & ID Number Integrity HC of Godfrey # 0053306 Report Period Beginning: 1/1/2016 Ending: 12/31/2016
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	154,359	14,720	6,881	175,960		175,960	(101)	175,859			1
2	Food Purchase		121,224		121,224		121,224		121,224			2
3	Housekeeping			83,522	83,522		83,522		83,522			3
4	Laundry		3,012	55,629	58,641		58,641		58,641			4
5	Heat and Other Utilities			98,817	98,817		98,817	1,800	100,617			5
6	Maintenance	34,845	11,419	29,482	75,746		75,746	330	76,076			6
7	Other (specify):*											7
8	TOTAL General Services	189,204	150,375	274,331	613,910		613,910	2,029	615,939			8
	B. Health Care and Programs											
9	Medical Director			24,250	24,250		24,250		24,250			9
10	Nursing and Medical Records	1,177,346	83,455	47,261	1,308,062		1,308,062		1,308,062			10
10a	Therapy			480,420	480,420		480,420		480,420			10a
11	Activities	59,683	2,686		62,369		62,369		62,369			11
12	Social Services	23,148		3,810	26,958		26,958		26,958			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Pharmacy Consult			4,596	4,596		4,596		4,596			15
16	TOTAL Health Care and Programs	1,260,177	86,141	560,337	1,906,655		1,906,655		1,906,655			16
	C. General Administration											
17	Administrative	50,415			50,415		50,415		50,415			17
18	Directors Fees											18
19	Professional Services			181,235	181,235		181,235	(148,186)	33,049			19
20	Dues, Fees, Subscriptions & Promotions			11,548	11,548		11,548	37	11,585			20
21	Clerical & General Office Expenses	31,056	23,924	41,180	96,160		96,160	100,387	196,547			21
22	Employee Benefits & Payroll Taxes			286,887	286,887		286,887	10,184	297,071			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,880	1,880		1,880	3,189	5,069			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,895	38,895		38,895	193	39,088			26
27	Other (specify):*											27
28	TOTAL General Administration	81,471	23,924	561,625	667,020		667,020	(34,196)	632,824			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,530,852	260,440	1,396,293	3,187,585		3,187,585	(32,167)	3,155,418			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			7,173	7,173		7,173		7,173			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,034	31,034		31,034	(12)	31,022			32
33	Real Estate Taxes			30,633	30,633		30,633		30,633			33
34	Rent-Facility & Grounds			233,388	233,388		233,388	6,144	239,532			34
35	Rent-Equipment & Vehicles							720	720			35
36	Other (specify):*											36
37	TOTAL Ownership			302,228	302,228		302,228	6,852	309,080			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			13	13		13		13			38
39	Ancillary Service Centers		177,344		177,344		177,344		177,344			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,262	133,262		133,262		133,262			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		177,344	133,275	310,619		310,619		310,619			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,530,852	437,784	1,831,796	3,800,432		3,800,432	(25,315)	3,775,117			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	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	(684)	30		9
10	Interest and Other Investment Income	(12)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(101)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,111)	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	(303)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (10,211)		\$	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)	(15,104)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (15,104)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (25,315)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Vending Revenue	\$ (303)	21	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
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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	(303)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Integrity HC of Godfrey# 0053306

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	(101)	0	0	0	0	0	0	0	0	0	0	(101)	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	1,800	0	0	0	0	0	0	0	0	0	1,800	5
6	Maintenance	0	330	0	0	0	0	0	0	0	0	0	330	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(101)	2,130	0	0	0	0	0	0	0	0	0	2,029	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	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	(148,186)	0	0	0	0	0	0	0	0	0	(148,186)	19
20	Fees, Subscriptions & Promotions	0	37	0	0	0	0	0	0	0	0	0	37	20
21	Clerical & General Office Expenses	(9,414)	109,801	0	0	0	0	0	0	0	0	0	100,387	21
22	Employee Benefits & Payroll Taxes	0	10,184	0	0	0	0	0	0	0	0	0	10,184	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,189	0	0	0	0	0	0	0	0	0	3,189	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	193	0	0	0	0	0	0	0	0	0	193	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(9,414)	(24,782)	0	0	0	0	0	0	0	0	0	(34,196)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(9,515)	(22,652)	0	0	0	0	0	0	0	0	0	(32,167)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Integrity HC of Godfrey # 0053306 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(684)	684	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12)	0	0	0	0	0	0	0	0	0	0	(12)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,144	0	0	0	0	0	0	0	0	0	6,144	34
35	Rent-Equipment & Vehicles	0	720	0	0	0	0	0	0	0	0	0	720	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(696)	7,548	0	0	0	0	0	0	0	0	0	6,852	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(10,211)	(15,104)	0	0	0	0	0	0	0	0	0	(25,315)	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 Alton	Alton	Senior Healthcare	Skokie	Mgmt Co.
A&F Partnership	35	Integrity HC of Anna	Anna			
Ted Lehrman	5	Integrity HC of Carbondale	Carbondale			
		Integrity HC of Chester	Chester			
		Integrity HC of Cobden	Cobden			
		Integrity HC of Columbia	Columbia			
		Integrity HC of Herrin	Herrin			

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	Utilities	\$	Senior Healthcare Management		\$ 1,800	\$ 1,800	1
2	V	6	Repairs		Senior Healthcare Management		330	330	2
3	V	19	Professional Services	150,000	Senior Healthcare Management		1,814	(148,186)	3
4	V	20	Licenses & Fees		Senior Healthcare Management		37	37	4
5	V	21	Office Supplies		Senior Healthcare Management		2,466	2,466	5
6	V	21	Office Expense		Senior Healthcare Management		629	629	6
7	V	21	Payroll		Senior Healthcare Management		106,706	106,706	7
8	V	22	Employee Benefits		Senior Healthcare Management		10,184	10,184	8
9	V	24	Travel/Seminar		Senior Healthcare Management		3,189	3,189	9
10	V	26	Insurance		Senior Healthcare Management		193	193	10
11	V	30	Depreciation Expense		Senior Healthcare Management		684	684	11
12	V	34	Rent Expense		Senior Healthcare Management		6,144	6,144	12
13	V	35	Equipment Lease		Senior Healthcare Management		720	720	13
14	Total			\$ 150,000			\$ 134,896	\$ * (15,104)	14

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

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 Marion	Marion				1
2			Integrity HC of Belleville	Belleville				2
3			Integrity HC of Ridgway	Ridgway				3
4			Integrity HC of Smithton	Smithton				4
5			Integrity HC of Wood River	Wood River				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Integrity HC of Godfrey # 0053306 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Integrity HC of Godfrey # 0053306 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Bank Leumi		X	Working Capital	Various	5/25/15	75,000	75,000	5/25/15	5.0000	31,034	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 75,000	\$ 75,000			\$ 31,034	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 75,000	\$ 75,000			\$ 31,034	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # N/A

* 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 2015 report.			\$	5,253	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.)			\$	30,903	2
3. Under or (over) accrual (line 2 minus line 1).			\$	25,650	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4,983	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.)			\$		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.			\$	30,633	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013		10	
		2014	30,363	11	
		2015	30,903	12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Integrity HC of Godfrey COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0053306

CONTACT PERSON REGARDING THIS REPORT Daniel S. Gaafar

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1. <u>24-2-01-33-02-204-038</u>	<u>Long Term Care Property</u>	\$ <u>30,903.36</u>	\$ <u>30,903.36</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>30,903.36</u></u>	\$ <u><u>30,903.36</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet: 21,330

B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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

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

None

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

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	New roof		2015		34,597	887	39	887		1,330
10	Signage		2015		2,625	67	39	67		83
11	Kitchen exhaust fan		2015		4,048	104	39	104		130
12										12
13	Replace front doors of facility		2016		6,232	73	39	73		73
14	Fix water damage to main level crawl space.		2016		4,236	50	39	50		50
15	Install new locks on new front doors		2016		2,609	31	39	31		31
16	Replace 25' of sewer pipe in basement		2016		2,840	33	39	33		33
17	New fire alarm installed		2016		16,857	198	39	198		198
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

*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 Godfrey

0053306

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			\$	\$		\$	\$		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)		\$ 74,044	\$ 1,443		\$ 1,443	\$	\$ 1,928	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$24,063	\$4,813	\$4,813	\$	5	\$7,220	71
72	Current Year Purchases	9,170	917	917		5	917	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$33,233	\$5,730	\$5,730	\$		\$8,137	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	107,277
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	7,173
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	7,173
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	10,065

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		68	11/24/14	\$ 233,388	20	10	3
4	Additions							4
5								5
6								6
7	TOTAL		68		\$ 233,388			7

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

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

N/A

N/A

9. Option to Buy: ☐ YES ☒ NO Terms: *

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

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

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

(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		N/A	\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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.	12/31/17	\$ 233,388
13.	12/31/18	\$ 233,388
14.	12/31/19	\$ 238,056

* 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.

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

☒ 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)	\$			

(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.

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	

(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		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	\$	3,321	\$ 215,046	\$	3,321	\$ 215,046	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,930	87,708		1,930	87,708	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,918	177,666		2,918	177,666	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				162,297		162,297	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs				15,047		15,047	10
	Academic Education		hrs							11
12	Other (specify): <u>X-Ray and Lab</u>	39-3								12
13	Other (specify): <u></u>									13
14	TOTAL			\$	8,169	\$ 480,420	\$ 177,344	8,169	\$ 657,764	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (35,424)	\$ (35,424)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,461,726	1,461,726	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,734	49,734	6
7	Other Prepaid Expenses	(7,000)	(7,000)	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Replacement Reserve</u>	124,169	124,169	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,593,205	\$ 1,593,205	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	74,044	74,044	15
16	Equipment, at Historical Cost	33,233	33,233	16
17	Accumulated Depreciation (book methods)	(10,065)	(10,065)	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)	\$ 97,212	\$ 97,212	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,690,417	\$ 1,690,417	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 473,926	\$ 473,926	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,690	144,690	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,224	5,224	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)	\$ 623,840	\$ 623,840	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	75,000	75,000	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)	\$ 75,000	\$ 75,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 698,840	\$ 698,840	46
47	TOTAL EQUITY(page 18, line 24)	\$ 991,577	\$ 991,577	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,690,417	\$ 1,690,417	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 876,643	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 876,643	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	264,934	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	(150,000)	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)	\$ 114,934	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 991,577	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Integrity HC of Godfrey

0053306

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 3,936,152	1
2	Discounts and Allowances for all Levels	(892,926)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,043,226	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	860,066	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 860,066	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		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	142,331	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	19,428	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 161,759	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	303	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 303	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,065,366	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	613,911	31
32	Health Care	1,906,655	32
33	General Administration	667,020	33
	B. Capital Expense		
34	Ownership	302,227	34
	C. Ancillary Expense		
35	Special Cost Centers	177,357	35
36	Provider Participation Fee	133,262	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,800,432	40
41	Income before Income Taxes (line 30 minus line 40)**	264,934	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 264,934	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,980,488	44
45	Private Pay - Net Inpatient Revenue	559,950	45
46	Medicare - Net Inpatient Revenue	1,241,962	46
47	Other-(specify)	(739,174)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,043,226	49

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,708	1,769	\$ 57,544	\$ 32.53	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,455	4,738	123,607	26.09	3
4	Licensed Practical Nurses	16,711	17,661	394,216	22.32	4
5	CNAs & Orderlies	43,410	46,290	503,634	10.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,745	5,068	59,683	11.78	10
11	Social Service Workers	1,798	1,887	23,148	12.27	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,083	15,225	154,359	10.14	15
16	Dishwashers					16
17	Maintenance Workers	2,047	2,229	34,845	15.63	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,119	2,228	50,415	22.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,061	2,192	30,735	14.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,481	2,675	33,009	12.34	31
32	Other Health Care MDS	2,402	2,597	65,336	25.16	32
33	Other(specify) Admissions			321		33
34	TOTAL (lines 1 - 33)	98,020	104,559	\$ 1,530,852 *	\$ 14.64	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	197	\$ 6,881	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	873	30,564	10-3	38
39	Pharmacist Consultant	92	4,596	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	109	3,810	12-3	45
46	Other(specify) MDS Consultant	477	16,697	10-3	46
47	HR Corp Compliance	192	9,580	21-3	47
48					48
49	TOTAL (lines 35 - 48)	1,940	\$ 72,128		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			
Name	Function	%	Amount
Laura Northway	Administrator		\$ 50,415
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 50,415
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
Sandberg Phoenix	Legal		\$ 17,381
Bradley Associates	Accounting		7,649
Johnson, Goldberg, & Brown	Accounting		3,000
MTS Consulting	Professional		3,205
Senior Healthcare Management	Prof/Mgmt Fees		150,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 181,235
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 72,353
Unemployment Compensation Insurance			41,873
FICA Taxes			108,216
Employee Health Insurance			70,232
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Expense			4,397
TOTAL (agree to Schedule V, line 22, col.8)			\$ 297,071
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 1,990
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks			
Illinois Council			8,400
River Bend Growth Assoc.			563
State Fire Marshall			195
Various			437
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 11,585
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Mileage			1,075
Home Office Mileage			3,189
Seminar Expense			
Education			805
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 5,069

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, give association name and amount.

Yes

Illinois Council - 8,400

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

5 Years

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

16,561

Line

10-2

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES
NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

X

N/A

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$

133,262

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?

Yes

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$

None

N/A

Indicate the amount.

\$

N/A

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No

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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes

HFS 3745 (N-4-99)

IL478-2471