

		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.

I. IDPH License ID Number: 0051011

Facility Name: INTEGRITY HC OF ANNA

Address: 315 S Brady Mill Rd Anna 62906

County: Union

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

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name: Aaron Mauer Telephone Number: 773-747-4506

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) 5/28/2021

(Type or Print Name) Alan Irni

(Title) CFO

Paid Preparer

(Signed) 5/27/2021

(Print Name and Title) Aaron Mauer President

(Firm Name & Address) GGM Associates, Inc. 6101 Nimtzy Parkway South Bend IN 46628

(Telephone) 773-747-4506 Fax # 773-747-4725

MAIL TO: BUREAU OF HEALTH FINANCE

ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES

201 S. Grand Avenue East

Springfield, IL 62763-0001

Phone # (217) 782-1630

HFS 3745 (N-4-99)

IL478-2471

Facility Name & ID Number INTEGRITY HC OF ANNA

0051011 Report Period Beginning: 01/01/20 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 <u>NA</u>					
	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	70	Skilled (SNF)	70	25,620	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	70	TOTALS	70	25,620	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	11,066	3,282	3,671	18,019	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,066	3,282	3,671	18,019	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.33%

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 06/01/10

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

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 70 and days of care provided 3,403

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **INTEGRITY HC OF ANNA** # **0051011** Report Period Beginning: **01/01/20** 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	156,917	13,065	5,533	175,515		175,515	(92)	175,423			1
2	Food Purchase		113,196		113,196		113,196		113,196			2
3	Housekeeping	100,805	9,360		110,165		110,165		110,165			3
4	Laundry	40,158	6,027		46,185		46,185		46,185			4
5	Heat and Other Utilities			104,963	104,963		104,963	2,283	107,246			5
6	Maintenance	38,881	28,015	11,938	78,834		78,834	2,076	80,910			6
7	Other (specify):*											7
8	TOTAL General Services	336,761	169,663	122,434	628,858		628,858	4,267	633,125			8
	B. Health Care and Programs											
9	Medical Director			11,908	11,908		11,908		11,908			9
10	Nursing and Medical Records	1,282,839	177,954	49,506	1,510,299		1,510,299	95,278	1,605,577			10
10a	Therapy			440,243	440,243		440,243		440,243			10a
11	Activities	46,932	2,846		49,778		49,778		49,778			11
12	Social Services	28,523		4,207	32,730		32,730		32,730			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			5,292	5,292		5,292		5,292			15
16	TOTAL Health Care and Programs	1,358,294	180,800	511,156	2,050,250		2,050,250	95,278	2,145,528			16
	C. General Administration											
17	Administrative	111,791			111,791		111,791		111,791			17
18	Directors Fees											18
19	Professional Services			215,690	215,690		215,690	(152,273)	63,417			19
20	Dues, Fees, Subscriptions & Promotions			9,430	9,430		9,430	72	9,502			20
21	Clerical & General Office Expenses	40,017	15,384	87,843	143,244		143,244	76,278	219,522			21
22	Employee Benefits & Payroll Taxes			215,128	215,128		215,128	169,747	384,875			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,820	4,820		4,820	2,797	7,617			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			180,181	180,181		180,181	571	180,752			26
27	Other (specify):*											27
28	TOTAL General Administration	151,808	15,384	713,092	880,284		880,284	97,192	977,476			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,846,863	365,847	1,346,682	3,559,392		3,559,392	196,736	3,756,128			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			60,881	60,881		60,881	(23,927)	36,954			30
31	Amortization of Pre-Op. & Org.			815	815		815		815			31
32	Interest			22,103	22,103		22,103	(1,638)	20,465			32
33	Real Estate Taxes			11,993	11,993		11,993		11,993			33
34	Rent-Facility & Grounds			507,434	507,434		507,434	8,812	516,246			34
35	Rent-Equipment & Vehicles							941	941			35
36	Other (specify):* Replacement Tax			3,321	3,321		3,321	(3,321)				36
37	TOTAL Ownership			606,547	606,547		606,547	(19,133)	587,414			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			167	167		167		167			38
39	Ancillary Service Centers		79,166		79,166		79,166		79,166			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			127,038	127,038		127,038		127,038			42
43	Other (specify):* Bad Debt Expense			79,322	79,322		79,322	(79,322)				43
44	TOTAL Special Cost Centers		79,166	206,527	285,693		285,693	(79,322)	206,371			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,846,863	445,013	2,159,756	4,451,632		4,451,632	98,281	4,549,913			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	(23,927)	30		9
10	Interest and Other Investment Income	(1,638)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(92)	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	(8,545)	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	(79,322)	43		24
25	Fund Raising, Advertising and Promotional	(15,569)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,321)	36		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)	\$ (132,414)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 230,695	Various	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 98,281		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0051011

Report Period Beginning:01/01/20

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
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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 ANNA # 0051011 Report Period Beginning: 01/01/20 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	(92)	0	0	0	0	0	0	0	0	0	0	(92)	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	(92)	4,359	0	0	0	0	0	0	0	0	0	4,267	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	71,110	0	0	0	0	0	0	0	0	95,278	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	71,110	0	0	0	0	0	0	0	0	95,278	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	(24,114)	99,089	1,303	0	0	0	0	0	0	0	0	76,278	21
22	Employee Benefits & Payroll Taxes	0	17,374	152,373	0	0	0	0	0	0	0	0	169,747	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	(24,114)	(32,370)	153,676	0	0	0	0	0	0	0	0	97,192	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(24,206)	(3,844)	224,786	0	0	0	0	0	0	0	0	196,736	29

Summary B

12/31/20

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

[illegible]

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 Cobden	Cobden	Integrity HCC Serivces	Skokie	Consulting Co.
A&F Realty, LLC	35	Integrity HC of Alton	Alton			
Ted Lerman	5	Integrity HC of Carbondale	Carbondale			
		Integrity HC of Columbia	Columbia			
		Integrity HC of Herrin	Herrin			
		Integrity HC of Belleville	Belleville			
		Integrity HC of Smithton	Smithton			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	\$	Integrity HCC Serivces		\$ 2,283	\$ 2,283	1
2	V	6	Maintenance		Integrity HCC Serivces		2,076	2,076	2
3	V	10	Nursing and Medical Records		Integrity HCC Serivces		24,168	24,168	3
4	V	19	Professional Services	198,000	Integrity HCC Serivces		45,727	(152,273)	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Integrity HCC Serivces		72	72	5
6	V	21	Clerical & General Office Expenses		Integrity HCC Serivces		99,089	99,089	6
7	V	22	Employee Benefits & Payroll Taxes		Integrity HCC Serivces		17,374	17,374	7
8	V	24	Travel and Seminar		Integrity HCC Serivces		2,797	2,797	8
9	V	26	Insurance-Prop.Liab.Malpractice		Integrity HCC Serivces		571	571	9
10	V	34	Rent		Integrity HCC Serivces		8,812	8,812	10
11	V	35	Equipment Lease		Integrity HCC Serivces		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	\$ 259,780	Integrity Communities Services		\$ 330,890	\$ 71,110	15
16	V	21	Clerical & General Office Expenses		Integrity Communities Services		1,303	1,303	16
17	V	22	Employee Benefits & Payroll Taxes		Integrity Communities Services		152,373	152,373	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			\$ 259,780			\$ 484,566	\$ * 224,786	39

* 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 Wood River	Wood River				1
2			Integrity HC of Godfrey	Godfrey				2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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27								27
28								28
29								29
30								30

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 ANNA # 0051011 Report Period Beginning: 01/01/20 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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NA Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	19,712	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.)			\$	28,101	2
3. Under or (over) accrual (line 2 minus line 1).			\$	8,389	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.)			\$	3,604	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.			\$	11,993	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	26,403	8	
		2016	26,658	9	
		2017	27,307	10	
		2018	27,451	11	
		2019	28,101	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME INTEGRITY HC OF ANNA COUNTY Union

FACILITY IDPH LICENSE NUMBER 0051011

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE 773-747-4506 FAX #: 773-474-4725

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 05-29-03-983-A	Nursing Facility	\$ 28,101.30	\$ 28,101.30
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 28,101.30	\$ 28,101.30

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.

A. Square Feet:

15,000

B. General Construction Type:

Exterior

Brick

Frame

Concrete / Steel

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

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

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

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:

12,225

2. Number of Years Over Which it is Being Amortized:

15

3. Current Period Amortization:

815

4. Dates Incurred:

06/01/10

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	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	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)	\$ 628,008	\$ 16,103		\$ 16,103	\$	\$ 130,887	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	\$ 90,192	\$ 16,630	\$ 18,038	\$ 1,408	5	\$ 76,518	71
72	Current Year Purchases	28,150	28,150	2,815	(25,335)	5	28,150	72
73	Fully Depreciated Assets	152,321					152,321	73
74								74
75	TOTALS	\$ 270,663	\$ 44,780	\$ 20,853	\$ (23,927)		\$ 256,989	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)			\$	898,671
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	60,883
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	36,956
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(23,927)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	387,876

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:315 South Brady Mill Road LLC.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1995	70	05/28/10	\$	20	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		70		\$			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 leaseN/A.
9. Option to Buy:☐ YES☒ NOTerms: *

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/ADescription:
(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.

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2		3	4	5	6	7	8				
	Service	Schedule V Line & Column Reference	Staff		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	\$	2,414	\$	193,837	\$	2,414	\$	193,837	1		
2	Licensed Speech and Language Development Therapist	10a-3	hrs		1,236		91,538		1,236		91,538	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	10a-3	hrs		2,328		154,868		2,328		154,868	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy	39-2	# of prescrpts					79,166			79,166	9		
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)													
10			hrs									10		
11	Academic Education		hrs									11		
12	Other (specify): X-Ray	39-2						4,243			4,243	12		
13	Other (specify): Lab	39-2						3,688			3,688	13		
14	TOTAL			\$	5,978	\$	440,243	\$	87,097		5,978	\$	527,340	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 584,655	\$ 584,655	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,669,072	2,669,072	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):	58,843	58,843	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,312,570	\$ 3,312,570	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	632,508	632,508	15
16	Equipment, at Historical Cost	262,150	262,150	16
17	Accumulated Depreciation (book methods)	(387,871)	(387,871)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(8,625)	(8,625)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 510,387	\$ 510,387	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,822,957	\$ 3,822,957	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 546,919	\$ 546,919	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	321,605	321,605	29
30	Accrued Salaries Payable	147,363	147,363	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)	\$ 1,015,887	\$ 1,015,887	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)	\$ 1,015,887	\$ 1,015,887	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,807,070	\$ 2,807,070	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,822,957	\$ 3,822,957	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,659,844	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,659,844	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,147,230	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)	\$ 1,147,230	17
	B. Transfers (Itemize):		
18	Rounding 5	(4)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (4)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,807,070	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number INTEGRITY HC OF ANNA

0051011

Report Period Beginning: 01/01/20

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	\$ 4,424,686	1
2	Discounts and Allowances for all Levels	(137,677)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,287,009	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	180,435	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 180,435	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,129,762	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	15	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,129,777	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,638	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,638	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Income</u>	3	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,598,862	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	628,858	31
32	Health Care	2,050,250	32
33	General Administration	880,284	33
	B. Capital Expense		
34	Ownership	606,547	34
	C. Ancillary Expense		
35	Special Cost Centers	285,693	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)*	\$ 4,451,632	40
41	Income before Income Taxes (line 30 minus line 40)**	1,147,230	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,147,230	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,010,080	44
45	Private Pay - Net Inpatient Revenue	472,705	45
46	Medicare - Net Inpatient Revenue	1,752,318	46
47	Other-(specify) <u>Net Patient Rev</u>	51,906	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,287,009	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.

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	1,966	2,032	\$ 71,798	\$ 35.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,199	7,306	169,703	23.23	3
4	Licensed Practical Nurses	9,143	9,283	427,247	46.02	4
5	CNAs & Orderlies	21,062	21,727	497,040	22.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,428	1,505	46,932	31.18	10
11	Social Service Workers	2,312	2,418	28,523	11.80	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,555	11,925	156,917	13.16	15
16	Dishwashers					16
17	Maintenance Workers	1,926	2,032	38,881	19.13	17
18	Housekeepers	4,204	4,332	100,805	23.27	18
19	Laundry	2,713	2,792	40,158	14.38	19
20	Administrator	2,080	2,080	111,791	53.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,935	2,118	40,017	18.89	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	2,140	2,272	55,801	24.56	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	2,353	2,470	61,250	24.80	33
34	TOTAL (lines 1 - 33)	72,016	74,292	\$ 1,846,863 *	\$ 24.86	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	\$ 5,533	1-3	35
36	Medical Director	Monthly	11,908	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	33,452	10-3	38
39	Pharmacist Consultant	Monthly	5,292	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	4,207	12-3	45
46	Other(specify) MDS	Monthly	16,054	10-3	46
47	HR Corp Compliance	Monthly	18,550	21-3	47
48	MARKETING CONSULTANT	Monthly	16,030	21-3	48
49	TOTAL (lines 35 - 48)		\$ 111,026		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

XX. GENERAL INFORMATION:

(1)	Are nursing employees (RN,LPN,NA) represented by a union?	<u>No</u>
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.	<u>Yes</u> <u>HCCI \$4,200</u>
(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?	<u>No</u> <u>N/A</u>
(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?	<u>No</u> <u>N/A</u>
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?	<u>YES</u> <u>5 YRS</u>
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.	\$ <u>14,915</u> Line <u>10</u>
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.	<u>YES</u>
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	<u>No</u> <u>N/A</u>
(9)	Are you presently operating under a sublease agreement?	<u>X</u> YES <u> </u> NO
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.	YES <u> </u> NO <u>X</u>
(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.	\$ <u>127,038</u>
(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.	<u>No</u>
(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?	<u>No</u>
(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.	<u>No</u>
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. Has any meal income been offset against related costs?	\$ <u>0</u> <u>N/A</u> Indicate the amount. \$ <u>N/A</u>
(16)	Travel and Transportation a. Are there costs included for out-of-state travel? If YES, attach a complete explanation. 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. c. What percent of all travel expense relates to transportation of nurses and patients? d. Have vehicle usage logs been maintained? e. Are all vehicles stored at the nursing home during the night and all other times when not in use? f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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.	<u>No</u> <u>N/A</u> <u>100%</u> <u>N/A</u> <u>N/A</u> <u>YES</u> <u>No</u> \$ <u>N/A</u>
(17)	Has an audit been performed by an independent certified public accounting firm? Firm Name:	<u>No</u> <u>N/A</u>
(18)	Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V?	<u>YES</u>
(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.	<u>YES</u>