

		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: 0051029

Facility Name: INTEGRITY HC OF CARBONDALE

Address: 120 North Tower Road Carbondale 62901
 Number City Zip Code

County: Jackson

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

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ 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

Facility Name & ID Number INTEGRITY HC OF CARBONDALE

0051029 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

NA

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>131</u>	Skilled (SNF)	<u>131</u>	<u>47,946</u>	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	<u>131</u>	TOTALS	<u>131</u>	<u>47,946</u>	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	<u>16,350</u>	<u>362</u>	<u>5,076</u>	<u>21,788</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,350</u>	<u>362</u>	<u>5,076</u>	<u>21,788</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.44%

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 131 and days of care provided 4,111

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ 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 CARBONDALE** # **0051029** 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	176,125	13,082	6,166	195,373		195,373	(10)	195,363			1
2	Food Purchase		143,366		143,366		143,366		143,366			2
3	Housekeeping	159,527	10,548		170,075		170,075		170,075			3
4	Laundry	51,234	9,630		60,864		60,864		60,864			4
5	Heat and Other Utilities			167,104	167,104		167,104	2,491	169,595			5
6	Maintenance	39,767	17,110	53,727	110,604		110,604	2,264	112,868			6
7	Other (specify):*											7
8	TOTAL General Services	426,653	193,736	226,997	847,386		847,386	4,745	852,131			8
	B. Health Care and Programs											
9	Medical Director			19,738	19,738		19,738		19,738			9
10	Nursing and Medical Records	1,522,233	250,193	45,678	1,818,104		1,818,104	64,574	1,882,678			10
10a	Therapy			445,111	445,111		445,111		445,111			10a
11	Activities	35,029	1,391		36,420		36,420		36,420			11
12	Social Services	65,349		4,719	70,068		70,068		70,068			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			6,525	6,525		6,525		6,525			15
16	TOTAL Health Care and Programs	1,622,611	251,584	521,771	2,395,966		2,395,966	64,574	2,460,540			16
	C. General Administration											
17	Administrative	57,010			57,010		57,010		57,010			17
18	Directors Fees											18
19	Professional Services			249,812	249,812		249,812	(166,115)	83,697			19
20	Dues, Fees, Subscriptions & Promotions			12,658	12,658		12,658	79	12,737			20
21	Clerical & General Office Expenses	50,130	18,873	98,398	167,401		167,401	91,266	258,667			21
22	Employee Benefits & Payroll Taxes			259,184	259,184		259,184	100,825	360,009			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,206	2,206		2,206	3,051	5,257			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			304,486	304,486		304,486	623	305,109			26
27	Other (specify):*											27
28	TOTAL General Administration	107,140	18,873	926,744	1,052,757		1,052,757	29,728	1,082,485			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,156,404	464,193	1,675,512	4,296,109		4,296,109	99,047	4,395,156			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			101,011	101,011		101,011	(36,423)	64,588			30
31	Amortization of Pre-Op. & Org.			815	815		815		815			31
32	Interest			22,417	22,417		22,417	(3,275)	19,142			32
33	Real Estate Taxes			49,435	49,435		49,435		49,435			33
34	Rent-Facility & Grounds			448,282	448,282		448,282	9,613	457,895			34
35	Rent-Equipment & Vehicles							1,026	1,026			35
36	Other (specify):*											36
37	TOTAL Ownership			621,960	621,960		621,960	(29,059)	592,901			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		171,792		171,792		171,792		171,792			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,686	187,686		187,686		187,686			42
43	Other (specify):* Bad Debt Expense			152,764	152,764		152,764	(152,764)				43
44	TOTAL Special Cost Centers		171,792	340,450	512,242		512,242	(152,764)	359,478			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,156,404	635,985	2,637,922	5,430,311		5,430,311	(82,776)	5,347,535			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	(36,423)	30		9
10	Interest and Other Investment Income	(3,275)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(10)	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	(2,925)	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	(152,764)	43		24
25	Fund Raising, Advertising and Promotional	(14,606)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (210,003)		\$	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)	\$ 127,227		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (82,776)		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#0051029

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
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number INTEGRITY HC OF CARBONDALE # 0051029 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	(10)	0	0	0	0	0	0	0	0	0	0	(10)	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	2,491	0	0	0	0	0	0	0	0	0	2,491	5
6	Maintenance	0	2,264	0	0	0	0	0	0	0	0	0	2,264	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10)	4,755	0	0	0	0	0	0	0	0	0	4,745	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	26,365	38,209	0	0	0	0	0	0	0	0	64,574	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	26,365	38,209	0	0	0	0	0	0	0	0	64,574	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	(166,115)	0	0	0	0	0	0	0	0	0	(166,115)	19
20	Fees, Subscriptions & Promotions	0	79	0	0	0	0	0	0	0	0	0	79	20
21	Clerical & General Office Expenses	(17,531)	108,097	700	0	0	0	0	0	0	0	0	91,266	21
22	Employee Benefits & Payroll Taxes	0	18,953	81,872	0	0	0	0	0	0	0	0	100,825	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,051	0	0	0	0	0	0	0	0	0	3,051	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	623	0	0	0	0	0	0	0	0	0	623	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(17,531)	(35,313)	82,572	0	0	0	0	0	0	0	0	29,728	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(17,541)	(4,193)	120,781	0	0	0	0	0	0	0	0	99,047	29

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	(36,423)	0	0	0	0	0	0	0	0	0	0	(36,423)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,275)	0	0	0	0	0	0	0	0	0	0	(3,275)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	9,613	0	0	0	0	0	0	0	0	0	9,613	34
35	Rent-Equipment & Vehicles	0	1,026	0	0	0	0	0	0	0	0	0	1,026	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(39,698)	10,639	0	0	0	0	0	0	0	0	0	(29,059)	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):*	(152,764)	0	0	0	0	0	0	0	0	0	0	(152,764)	43
44	TOTAL Special Cost Centers	(152,764)	0	0	0	0	0	0	0	0	0	0	(152,764)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(210,003)	6,446	120,781	0	0	0	0	0	0	0	0	(82,776)	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 Cobden	Cobden	Integrity HCC Serivces	Skokie	Consulting Co.
A&F Realty LLC	35	Integrity HC of Alton	Alton			
Ted Lerman	5	Integrity HC of Belleville	Belleville			
		Integrity HC of Columbia	Columbia			
		Integrity HC of Herrin	Herrin			
		Integrity HC of Anna	Anna			
		Integrity HC of Smithton	Smithton			

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	\$	Integrity HCC Serivces		\$ 2,491	\$ 2,491	1
2	V	6	Maintenance		Integrity HCC Serivces		2,264	2,264	2
3	V	10	Nursing and Medical Records		Integrity HCC Serivces		26,365	26,365	3
4	V	19	Professional Services	216,000	Integrity HCC Serivces		49,885	(166,115)	4
5	V	20	Dues, Fees, Subscriptions & Promotions		Integrity HCC Serivces		79	79	5
6	V	21	Clerical & General Office Expenses		Integrity HCC Serivces		108,097	108,097	6
7	V	22	Employee Benefits & Payroll Taxes		Integrity HCC Serivces		18,953	18,953	7
8	V	24	Travel and Seminar		Integrity HCC Serivces		3,051	3,051	8
9	V	26	Insurance-Prop.Liab.Malpractice		Integrity HCC Serivces		623	623	9
10	V	34	Rent		Integrity HCC Serivces		9,613	9,613	10
11	V	35	Equipment Lease		Integrity HCC Serivces		1,026	1,026	11
12	V								12
13	V								13
14	Total			\$ 216,000			\$ 222,446	\$ * 6,446	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	\$ 139,583	Integrity Communities		\$ 177,792	\$ 38,209	15
16	V	21	Clerical & General Office Expenses		Integrity Communities		700	700	16
17	V	22	Employee Benefits & Payroll Taxes		Integrity Communities		81,872	81,872	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			\$ 139,583			\$ 260,364	\$ * 120,781	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
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

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 CARBONDALE # 0051029 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

12/31/20

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

Line #

HFS 3745 (N-4-99)

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.	\$	(57,892)	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.)			\$	49,830	2
3. Under or (over) accrual (line 2 minus line 1).			\$	107,722	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.)			\$	(58,287)	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.			\$	49,435	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	46,354	8	
		2016	46,674	9	
		2017	47,803	10	
		2018	48,381	11	
		2019	49,830	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 CARBONDALE COUNTY Jackson

FACILITY IDPH LICENSE NUMBER 0051029

CONTACT PERSON REGARDING THIS REPORT Aaron Mauer

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 15-19-126-004	Long Term Care Property	\$ 49,829.88	\$ 49,829.88
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 49,829.88	\$ 49,829.88

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:

B. General Construction Type:

Exterior Brick

Frame

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:

Prior to 06/01/10

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	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	Cooling System		2010		22,782	584	39	584		6,132
10										10
11	Sprinklers		2011		319,061	8,181	39	8,181		76,356
12	Concrete Work		2011		29,900	767	39	767		7,030
13	Roof		2011		98,000	2,513	39	2,513		23,031
14										14
15	Rooftop Condenser and 5 Ton Bryant Gas / Elect Unit		2013		16,513	423	39	423		3,174
16	Drain Pipe System in hallways and kitchen		2013		28,982	743	39	743		5,573
17	Wiring for Nurse Stations and Kiosks		2013		19,151	491	39	491		3,601
18										18
19	Paint Halls in South Hallway		2014		11,361	291	39	291		2,038
20										20
21	Skim coat and paint walls in south hallway		2015		11,361	291	39	291		1,589
22	Redo asphalt in front & back parking lots		2015		62,000	1,590	39	1,590		8,678
23										23
24	30 crome faucet and 100 door handles		2016		2,852	73	39	73		326
25	Plumbing shields max ADA covers		2016		1,665	43	39	43		191
26	Architechrtural Services for IDPH review		2016		8,502	218	39	218		972
27	Negative air fan / Air Scrubbler, HEPA vacuuming, clean walls		2016		71,199	1,826	39	1,826		8,139
28	and ceiling, clean floors, remove suspended ceiling tile									28
29	in rooms 1, 3-8, 10-26, 31 - 36, break room, bathroom									29
30	and kitchen.									30
31	Painted courtyards and new siding		2016		2,700	69	39	69		308
32	Kawneer swing doors		2016		2,320	59	39	59		264
33	Sewer line replacement		2016		8,800	226	39	226		1,006
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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

1	2	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	Tile and new carpet for Vestibule, install ceiling system and	2016	\$ 77,218	\$ 1,980	39	\$ 1,826	\$ (154)	\$ 8,828	37
38	lighting in lobby, install tile, cove base and carpeting in lobby,								38
39	install reception desk, pendant light and drywall in lobby.								39
40	Lobby window tinting	2016	10,498	269	39	269		1,199	40
41	Waterproofing basement	2016	9,610	246	39	246		1,098	41
42	Call light system	2016	35,649	914	39	914		4,075	42
43									43
44	Paint 56 patient rooms and bathrooms	2017	93,409	2,395	39	2,395		8,384	44
45	Sewer line service	2017	104,923	2,690	39	2,690		9,416	45
46	Deaved egress install	2017	5,969	153	39	153		537	46
47	Condensing unit install	2017	5,625	144	39	144		504	47
48	New Roof	2017	91,310	2,341	39	2,341		8,196	48
49	Blackout roller shades installed in 29 resident rooms	2017	27,781	712	39	712		2,493	49
50	New HVAC and blower assembly	2017	11,814	303	39	303		1,059	50
51									51
52	Sewer line repair - replacing 60 feet of 4" cast iron sewer	2018	199,786	5,123	39	5,123		12,806	52
53	Installing new flooring	2018	113,594	2,913	39	2,913		7,281	53
54	Installation of new flat Lexan Face replacement for existing sign	2018	1,223	31	39	31		79	54
55	Installation of closet system in 10 rooms	2018	1,747	45	39	45		112	55
56	Replacement of existing air conditioning - Trane	2018	15,000	385	39	385		961	56
57									57
58	Sewer Lines	2019	160,000	4,103	39	4,103		6,154	58
59	New Interior Vestibule	2019	3,990	102	39	77	(26)	153	59
60	New Interior Vestibule	2019	3,990	102	39	77	(26)	153	60
61	Washer Installation	2019	9,459	243	39	40	(202)	364	61
62	Fire Alarm Repairs	2019	6,725	172	39	29	(144)	259	62
63	New Door	2019	3,919	100	39	8	(92)	151	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,710,387	\$ 43,856		\$ 43,213	\$ (643)	\$ 222,672	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	\$ 85,347	\$ 14,078	\$ 17,069	\$ 2,991	5	\$ 72,782	71
72	Current Year Purchases	43,079	43,079	4,308	(38,771)	5	43,079	72
73	Fully Depreciated Assets	121,799				5	121,799	73
74								74
75	TOTALS	\$ 250,225	\$ 57,157	\$ 21,377	\$ (35,780)		\$ 237,660	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,960,612	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,013	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,590	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (36,423)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 460,332	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 120 North Tower 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	131	08/01/15	\$	20	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		131		\$			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
9. Option to Buy: ☐ YES ☒ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ N/A Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	\$	2,768	\$ 176,522	\$	2,768	\$ 176,522	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		943	81,858		943	81,858	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		2,420	186,731		2,420	186,731	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				171,792		171,792	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-ray	39-2					6,050		6,050	12
13	Other (specify): Lab	39-2					5,442		5,442	13
14	TOTAL			\$	6,132	\$ 445,111	\$ 183,284	6,132	\$ 628,395	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	\$ (41,333)	\$ (41,333)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,548,885	1,548,885	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):	397,271	397,271	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,904,823	\$ 1,904,823	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,570,385	1,570,385	15
16	Equipment, at Historical Cost	250,225	250,225	16
17	Accumulated Depreciation (book methods)	(460,325)	(460,325)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(8,625)	(8,625)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,363,885	\$ 1,363,885	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,268,708	\$ 3,268,708	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 974,026	\$ 974,026	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	370,760	370,760	29
30	Accrued Salaries Payable	142,241	142,241	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)	\$ 1,487,027	\$ 1,487,027	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,250,000	1,250,000	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)	\$ 1,250,000	\$ 1,250,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,737,027	\$ 2,737,027	46
47	TOTAL EQUITY(page 18, line 24)	\$ 531,681	\$ 531,681	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,268,708	\$ 3,268,708	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (640,533)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (640,533)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,172,216	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)	\$ 1,172,216	17
	B. Transfers (Itemize):		
18	Rounding	(2)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 531,681	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number INTEGRITY HC OF CARBONDALE

0051029

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	\$ 5,209,058	1
2	Discounts and Allowances for all Levels	(139,762)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,069,296	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	139,011	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 139,011	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	1,389,039	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		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)	\$ 1,389,039	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,275	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,275	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Misc Rev	1,906	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,906	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,602,527	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	847,386	31
32	Health Care	2,395,966	32
33	General Administration	1,052,757	33
	B. Capital Expense		
34	Ownership	621,960	34
	C. Ancillary Expense		
35	Special Cost Centers	512,242	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)*	\$ 5,430,311	40
41	Income before Income Taxes (line 30 minus line 40)**	1,172,216	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,172,216	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,849,634	44
45	Private Pay - Net Inpatient Revenue	75,735	45
46	Medicare - Net Inpatient Revenue	1,956,617	46
47	Other-(specify) <u>Net Patient Revenue</u>	187,310	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,069,296	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	5,574	5,737	\$ 82,616	\$ 14.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,501	3,501	372,469	106.39	3
4	Licensed Practical Nurses	20,642	21,158	485,164	22.93	4
5	CNAs & Orderlies	26,324	27,127	505,959	18.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants			35,029		10
11	Social Service Workers	1,950	2,038	65,349	32.07	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,446	9,768	176,125	18.03	15
16	Dishwashers					16
17	Maintenance Workers	1,922	1,974	39,767	20.15	17
18	Housekeepers	12,744	13,307	159,527	11.99	18
19	Laundry	5,276	5,485	51,234	9.34	19
20	Administrator	2,080	2,080	57,010	27.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,776	5,003	50,130	10.02	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	2,339	2,530	76,026	30.05	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,574	99,708	\$ 2,156,405 *	\$ 21.63	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,166	1-3	35
36	Medical Director	Monthly	19,738	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	30,017	10-3	38
39	Pharmacist Consultant	Monthly	6,525	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	4,719	12-3	45
46	Other(specify) MDS	Monthly	15,662	10-3	46
47	HR Corp Compliance	Monthly	18,650	21-3	47
48	MARKETING CONSULTANT	Monthly	13,634	21-3	48
49	TOTAL (lines 35 - 48)	Monthly	\$ 115,110		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

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Hamm, Michelle L.	Administrator	0	\$ 57,010
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 57,010
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
Bradley & Associates	Accounting Fees	\$	6,388
Johnson, Goldberg, & Brown	Accounting Fees		3,000
GGM Associates Inc	Accounting Fees		6,000
Integrity HCC	Management Fees		216,000
BANK LEUMI	Legal Fees		6,473
MTS CONSULTING LLC	Professional Fees		4,981
Integrity HCC Services LLC	Professional Fees		500
Sandberg Phoenix & Von Gontard P.	Collection Costs		6,171
MARKOFF LAW LLC	Collection Costs		300
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 249,812
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance	\$		47,666
Unemployment Compensation Insurance			18,649
FICA Taxes			258,279
Employee Health Insurance			27,506
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Benefits Other			7,909
TOTAL (agree to Schedule V, line 22, col.8)			\$ 360,009
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	\$		1,650
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed)			
Patient Background Checks			
Secretary of State			238
HCCI			4,200
Carbondale Chamber of Commerce			523
Jackson County Health Dept			280
Other fees			5,846
Less: Public Relations Expense	(		)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 12,737
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel	\$		
In-State Travel			
AUTO ALLOWANCE			466
Mileage Reimbursement			4,792
Seminar Expense			
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 5,258

*** 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? Yes
If YES, give association name and amount. HCCI \$4,200

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,844 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? X YES NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 187,686
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? No

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. YES
Attach invoices and a summary of services for all architect and appraisal fees.