

		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: <u>0053306</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>INTEGRITY HC OF GODFREY</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/20</u> to <u>12/31/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1623 29 W Delmer Ave</u> <u>Godfrey</u> <u>62035</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Madison</u>			
Telephone Number: <u>708-426-2315</u> Fax # <u>708-426-2415</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>11/24/14</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: _____			
Telephone Number: (_____) _____			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ <u>5/28/2021</u> (Date)	
		(Type or Print Name) <u>Alan Irni</u>	
		(Title) <u>CFO</u>	
		Paid Preparer	
		(Signed) _____ <u>5/27/2021</u> (Date)	
		(Print Name and Title) <u>Aaron Mauer</u> <u>President</u>	
		(Firm Name & Address) <u>GGM Associates, Inc.</u> <u>6101 Nimitz Parkway South Bend IN 46628</u>	
		(Telephone) <u>773-747-4506</u> Fax # <u>773-747-4725</u>	
		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 GODFREY

0053306 Report Period Beginning: 1/1/20 Ending: 12/31/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

NA

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,128	2,174	2,255	16,557	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,128	2,174	2,255	16,557	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.53%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 11/24/14

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11/24/14 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 68 and days of care provided 1,861

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 GODFREY** # **0053306** Report Period Beginning: **1/1/20** Ending: **12/31/20**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	158,453	12,022	4,054	174,529		174,529	(63)	174,466			1
2	Food Purchase		102,440		102,440		102,440		102,440			2
3	Housekeeping	122,381	9,681		132,062		132,062		132,062			3
4	Laundry	25,667	6,226		31,893		31,893		31,893			4
5	Heat and Other Utilities			95,872	95,872		95,872	2,283	98,155			5
6	Maintenance	36,964	21,309	14,081	72,354		72,354	2,076	74,430			6
7	Other (specify):*											7
8	TOTAL General Services	343,465	151,678	114,007	609,150		609,150	4,296	613,446			8
	B. Health Care and Programs											
9	Medical Director			22,323	22,323		22,323		22,323			9
10	Nursing and Medical Records	1,231,598	194,739	48,706	1,475,043		1,475,043	36,092	1,511,135			10
10a	Therapy			275,491	275,491		275,491		275,491			10a
11	Activities	62,104	3,719		65,823		65,823		65,823			11
12	Social Services	22,686		5,330	28,016		28,016		28,016			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			5,076	5,076		5,076		5,076			15
16	TOTAL Health Care and Programs	1,316,388	198,458	356,926	1,871,772		1,871,772	36,092	1,907,864			16
	C. General Administration											
17	Administrative	66,617			66,617		66,617		66,617			17
18	Directors Fees											18
19	Professional Services			226,560	226,560		226,560	(152,273)	74,287			19
20	Dues, Fees, Subscriptions & Promotions			11,521	11,521		11,521	72	11,593			20
21	Clerical & General Office Expenses	33,531	22,697	92,984	149,212		149,212	81,778	230,990			21
22	Employee Benefits & Payroll Taxes			248,648	248,648		248,648	42,923	291,571			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,005	1,005		1,005	2,797	3,802			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			149,732	149,732		149,732	571	150,303			26
27	Other (specify):*											27
28	TOTAL General Administration	100,148	22,697	730,450	853,295		853,295	(24,132)	829,163			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,760,001	372,833	1,201,383	3,334,217		3,334,217	16,255	3,350,472			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			38,082	38,082		38,082	(16,408)	21,674			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,081	21,081		21,081	(1,454)	19,627			32
33	Real Estate Taxes			38,968	38,968		38,968		38,968			33
34	Rent-Facility & Grounds			240,238	240,238		240,238	8,812	249,050			34
35	Rent-Equipment & Vehicles							941	941			35
36	Other (specify):*											36
37	TOTAL Ownership			338,369	338,369		338,369	(8,109)	330,260			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			525	525		525		525			38
39	Ancillary Service Centers		112,287		112,287		112,287		112,287			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			133,282	133,282		133,282		133,282			42
43	Other (specify):* Bad Debt Expense			214,765	214,765		214,765	(214,765)				43
44	TOTAL Special Cost Centers		112,287	348,572	460,859		460,859	(214,765)	246,094			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,760,001	485,120	1,888,324	4,133,445		4,133,445	(206,619)	3,926,826			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	(16,408)	30		9
10	Interest and Other Investment Income	(1,454)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(214,765)	43		24
25	Fund Raising, Advertising and Promotional	(17,529)	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)	\$ (250,219)		\$	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)	\$ 43,600	Various	36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (206,619)		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

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 GODFREY

0053306

Report Period Beginning:

1/1/20

Ending:

12/31/20

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(63)	0	0	0	0	0	0	0	0	0	0	(63)	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	(63)	4,359	0	0	0	0	0	0	0	0	0	4,296	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	11,924	0	0	0	0	0	0	0	0	36,092	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	11,924	0	0	0	0	0	0	0	0	36,092	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	(17,529)	99,089	218	0	0	0	0	0	0	0	0	81,778	21
22	Employee Benefits & Payroll Taxes	0	17,374	25,549	0	0	0	0	0	0	0	0	42,923	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	(17,529)	(32,370)	25,767	0	0	0	0	0	0	0	0	(24,132)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,592)	(3,844)	37,691	0	0	0	0	0	0	0	0	16,255	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number INTEGRITY HC OF GODFREY # 0053306 Report Period Beginning: 1/1/20 Ending: 12/31/20

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(16,408)	0	0	0	0	0	0	0	0	0	0	(16,408)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,454)	0	0	0	0	0	0	0	0	0	0	(1,454)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,812	0	0	0	0	0	0	0	0	0	8,812	34
35	Rent-Equipment & Vehicles	0	941	0	0	0	0	0	0	0	0	0	941	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(17,862)	9,753	0	0	0	0	0	0	0	0	0	(8,109)	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):*	(214,765)	0	0	0	0	0	0	0	0	0	0	(214,765)	43
44	TOTAL Special Cost Centers	(214,765)	0	0	0	0	0	0	0	0	0	0	(214,765)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(250,219)	5,909	37,691	0	0	0	0	0	0	0	0	(206,619)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steven Blisko	60	Integrity HC of Carbonedale	Carbonedale	Integrity HCC 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 Cobden	Cobden			
		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		\$ 2,283	\$ 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.

X YES NO

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

1		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	\$ 43,558	Integrity Communities Services		\$ 55,482	\$ 11,924	15
16	V	21	Clerical & General Office Expenses				218	218	16
17	V	22	Employee Benefits & Payroll Taxes				25,549	25,549	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			\$ 43,558			\$ 81,249	\$ * 37,691	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 Columbia	Columbia				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 GODFREY # 0053306 Report Period Beginning: 1/1/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	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.	\$	3,407	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.)			\$	34,585	2
3. Under or (over) accrual (line 2 minus line 1).			\$	31,178	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.)			\$	7,790	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.			\$	38,968	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	30,903	8		
	2016	31,671	9		
	2017	32,603	10		
	2018	34,073	11		
	2019	34,585	12		
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME INTEGRITY HC OF GODFREY COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0053306

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. 24-2-01-33-02-204-038	Long Term Care Property	\$ 34,585.12	\$ 34,585.12
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 34,585.12	\$ 34,585.12

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 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: 21,330

B. General Construction Type: Exterior BrickFrame ConcreteNumber of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	New Roof			2015	34,597	887	39	887		4,877	9
10	Signage			2015	2,625	67	39	67		352	10
11	Kitchen Exhaust Fan			2015	4,048	104	39	104		546	11
12											12
13	Replace front doors of facility			2016	6,232	160	39	160		713	13
14	Fix water damage to main level crawl space			2016	4,236	109	39	109		485	14
15	Install new lockson new front doors			2016	2,609	67	39	67		299	15
16	Replace 25 ' of sewer pipe in basement			2016	2,840	73	39	73		325	16
17	New Fire Alarm Installed			2016	16,857	432	39	432		1,926	17
18											18
19	Electrical and lighting work and wallcovering in main lobby										19
20	and prep walls, winstall wallcovering, paint ceiling beams,										20
21	pipes, wire covers, doorframes and shopfront			2017	46,821	1,201	39	1,201		4,201	21
22	New Water heater			2017	3,515	90	39	90		315	22
23											23
24	Wiring for wireless connection for PCC			2018	1,160	30	39	30		74	24
25	Installation of 11 new skylights			2018	9,942	255	39	255		637	25
26											26
27	Repair & Paint Damaged Walls			2019	3,000	77	39	77		115	27
28	Flat light Panel			2019	3,003	77	39	77		116	28
29	Cove Base Repairs			2019	3,500	90	39	90		135	29
30	Rebuilding Washers			2019	6,422	165	39	165		247	30
31	New Range			2019	1,450	37	39	37		56	31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 152,857	\$ 3,919		\$ 3,919	\$	\$ 15,418	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	\$ 78,316	\$ 13,254	\$ 15,663	\$ 2,409	5	\$ 57,964	71
72	Current Year Purchases	20,908	20,908	2,091	(18,817)	5	20,908	72
73	Fully Depreciated Assets	39,503				5	39,503	73
74								74
75	TOTALS	\$ 138,727	\$ 34,162	\$ 17,754	\$ (16,408)		\$ 118,375	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)			\$	291,584
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	38,081
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	21,673
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(16,408)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	133,793

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 1623 West Delmar Avenue LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

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

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	\$	1,707	\$ 128,779	\$	1,707	\$ 128,779	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		177	22,770		177	22,770	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		1,645	123,943		1,645	123,943	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				112,287		112,287	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): X-Ray	39-2					3,015		3,015	12
13	Other (specify): Lab	39-2					4,790		4,790	13
14	TOTAL			\$	3,528	\$ 275,492	\$ 120,092	3,528	\$ 395,584	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 43,294	\$ 43,294	1
2	Cash-Patient Deposits	1,919,747	1,919,747	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,204	60,204	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	231,112	231,112	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,254,357	\$ 2,254,357	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	152,857	152,857	15
16	Equipment, at Historical Cost	138,728	138,728	16
17	Accumulated Depreciation (book methods)	(133,794)	(133,794)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 157,791	\$ 157,791	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,412,148	\$ 2,412,148	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 487,668	\$ 487,668	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	350,406	350,406	29
30	Accrued Salaries Payable	96,324	96,324	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)	\$ 934,398	\$ 934,398	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)	\$ 934,398	\$ 934,398	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,477,750	\$ 1,477,750	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,412,148	\$ 2,412,148	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,231,786	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,231,786	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	245,968	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)	\$ 245,968	17
	B. Transfers (Itemize):		
18	Rounding	(4)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (4)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,477,750	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number INTEGRITY HC OF GODFREY

0053306

Report Period Beginning: 1/1/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,872,922	1
2	Discounts and Allowances for all Levels	(70,555)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,802,367	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	93,934	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 93,934	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	481,323	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	(30)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	236	20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 481,529	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,454	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,454	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income	118	28
28a	Misc Income	11	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 129	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,379,413	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	609,150	31
32	Health Care	1,871,772	32
33	General Administration	853,295	33
	B. Capital Expense		
34	Ownership	338,369	34
	C. Ancillary Expense		
35	Special Cost Centers	460,859	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)*	\$ 4,133,445	40
41	Income before Income Taxes (line 30 minus line 40)**	245,968	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 245,968	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,108,162	44
45	Private Pay - Net Inpatient Revenue	274,515	45
46	Medicare - Net Inpatient Revenue	998,403	46
47	Other-(specify) <u>Net Patient Revenue</u>	421,287	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,802,367	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	1,886	1,965	\$ 66,030	\$ 33.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,757	2,786	203,871	73.18	3
4	Licensed Practical Nurses	14,998	15,672	364,201	23.24	4
5	CNAs & Orderlies	21,225	21,716	392,519	18.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,790	5,188	62,104	11.97	10
11	Social Service Workers			22,686		11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,182	12,751	158,453	12.43	15
16	Dishwashers					16
17	Maintenance Workers	762	769	36,964	48.07	17
18	Housekeepers	6,663	6,838	122,381	17.90	18
19	Laundry	2,684	2,744	25,667	9.35	19
20	Administrator	2,080	2,080	66,617	32.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,469	2,597	33,531	12.91	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	2,450	2,655	98,813	37.22	31
32	Other Health Care(specify)					32
33	Other(specify) MDS	3,089	3,251	106,165	32.66	33
34	TOTAL (lines 1 - 33)	78,035	81,012	\$ 1,760,002 *	\$ 21.73	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	\$ 4,054	1-3	35
36	Medical Director	Monthly	22,323	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	32,652	10-3	38
39	Pharmacist Consultant	Monthly	5,076	15-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	5,330	12-3	45
46	Other(specify) MDS	Monthly	16,054	10-3	46
47	HR Corp Compliance	Monthly	18,550	21-3	47
48	MARKETING CONSULTANT	Monthly	15,938	21-3	48
49	TOTAL (lines 35 - 48)		\$ 119,977		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

Facility Name & ID Number		INTEGRITY HC OF GODFREY		STATE OF ILLINOIS		# 0053306		Report Period Beginning:		1/1/20		Page 21		Ending:		12/31/20	
XIX. SUPPORT SCHEDULES																	
A. Administrative Salaries				Ownership				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions					
Name		Function		%		Amount		Description		Amount		Description		Amount			
LISZEWSKI, KATHRYN		Administrator		0		\$ 48,649		Workers' Compensation Insurance		\$ 44,007		IDPH License Fee		\$ 3,860			
McKinnon, Lori L.		Administrator		0		17,968		Unemployment Compensation Insurance		15,072		Advertising: Employee Recruitment					
								FICA Taxes		172,063		Health Care Worker Background Check					
								Employee Health Insurance		54,660		(Indicate # of checks performed)					
								Employee Meals				Patient Background Checks					
								Illinois Municipal Retirement Fund (IMRF)*				Allscripts		1,175			
								Employee Other Benefits		5,769		HCCI		4,200			
												Clia Laboratory		180			
												Secretary of State		302			
												Other Fees		1,876			
												Less: Public Relations Expense		()			
												Non-allowable advertising		()			
												Yellow page advertising		()			
TOTAL (agree to Schedule V, line 17, col. 1)						\$ 66,617						TOTAL (agree to Sch. V,		\$ 11,593			
(List each licensed administrator separately.)								line 22, col.8)		\$ 291,571		line 20, col. 8)					
B. Administrative - Other								E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**					
Description						Amount		Description		Line #		Amount		Description		Amount	
						\$						\$		Out-of-State Travel		\$	
TOTAL (agree to Schedule V, line 17, col. 3)						\$								In-State Travel			
(Attach a copy of any management service agreement)														AUTO ALLOWANCE		3,132	
C. Professional Services												Mileage Reimbursement				670	
Vendor/Payee		Type				Amount											
Bradley & Associates		Accounting Fees				\$ 1770								Seminar Expense			
Johnson, Goldberg, & Brown		Accounting Fees				3000											
GGM Associates Inc		Accounting Fees				6000											
Integrity HCC		Management Fees				214,500								Entertainment Expense		()	
BANK LEUMI		Legal Fees				936								(agree to Sch. V,			
Integrity HCC		Professional fees				354								line 24, col. 8)			
Sandberg Phoenix & Von Gontard P.		Collection Costs				(0)								TOTAL		\$ 3,802	
TOTAL (agree to Schedule V, line 19, column 3)						\$ 226,560		TOTAL		\$							
(For legal fee disclosure, see page 39 of instructions)																	
* Attach copy of IMRF notifications																	
**See instructions.																	

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
HCCI \$4,200

(3)

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

No
N/A

(4)

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

No
N/A

(5)

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

YES
5 YRS

(6)

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

\$ 13,857 Line 10

(7)

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

YES

(8)

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

NO
N/A

(9)

Are you presently operating under a sublease agreement?

X YES NO

(10)

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

X

(11)

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

\$ 133,282

(12)

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

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

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?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

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

\$ 0
N/A
Indicate the amount. \$ N/A

(16)

Travel and Transportation

a.

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

No

b.

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

No
N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

100%

d.

Have vehicle usage logs been maintained?

N/A

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
N/A

(17)

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

No
N/A

(18)

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

YES

(19)

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

YES