

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0051045

Facility Name: INTEGRITY HC OF HERRIN

Address: 1900 NORTH PARK AVE HERRIN 62948
Number City Zip Code

County: WILLIAMSON

Telephone Number: 708-236-0000 Fax # 708-236-0001

HFS ID Number:

Date of Initial License for Current Owners: 06/01/2010

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: DANIEL GAAFAR Telephone Number: 317-237-5500
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 1/1/25 to 12/31/25 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)
(Type or Print Name) ALAN IRNI
(Title) CFO

Paid Preparer

(Signed)
(Print Name and Title) DANIEL S. GAAFAR PARTNER
(Firm Name & Address) BRADLEY AND ASSOCIATES 201 S. CAPITOL, STE 700, INDIANAPOLIS, IN 46225
(Telephone) 317-237-5500 Fax # 317-237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number INTEGRITY HC OF HERRIN # 0051045 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

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 06/01/2010

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 06/01/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 70

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025
* All facilities other than governmental must report on the accrual basis.

	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>27</u>	Skilled (SNF)	<u>27</u>	<u>9,855</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>22</u>	Intermediate (ICF)	<u>22</u>	<u>8,030</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>49</u>	TOTALS	<u>49</u>	<u>17,885</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	<u>1,241</u>	<u>3,572</u>	<u>797</u>	<u>16</u>	<u>1,268</u>	<u>858</u>	<u>131</u>	<u>7,883</u>	8
9	SNF/PED									9
10	ICF	<u>1,011</u>	<u>2,910</u>	<u>649</u>		<u>1,034</u>		<u>106</u>	<u>5,710</u>	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	<u>2,252</u>	<u>6,482</u>	<u>1,446</u>	<u>16</u>	<u>2,302</u>	<u>858</u>	<u>237</u>	<u>13,593</u>	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 76.00%

Facility Name & ID Number **INTEGRITY HC OF HERRIN** # **0051045** Report Period Beginning: **1/1/25** Ending: **12/31/25**
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	204,260	10,019	6,992	221,271		221,271		221,271			1
2	Food Purchase		105,551		105,551		105,551	26	105,577			2
3	Housekeeping	130,253	10,594		140,847		140,847		140,847			3
4	Laundry	48,066	3,578		51,644		51,644		51,644			4
5	Heat and Other Utilities			54,920	54,920		54,920	2,098	57,018			5
6	Maintenance	40,219	48,084		88,303		88,303	8,860	97,163			6
7	Other (specify):*											7
8	TOTAL General Services	422,798	177,826	61,912	662,536		662,536	10,984	673,520			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,255,299	78,302	42,255	1,375,856		1,375,856		1,375,856			10
10a	Therapy			213,042	213,042		213,042		213,042			10a
11	Activities	83,350	4,275		87,625		87,625		87,625			11
12	Social Services	29,928	5,001		34,929		34,929		34,929			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consult			4,077	4,077		4,077		4,077			15
16	TOTAL Health Care and Programs	1,368,577	87,578	271,374	1,727,529		1,727,529		1,727,529			16
	C. General Administration											
17	Administrative	77,784			77,784		77,784		77,784			17
18	Directors Fees											18
19	Professional Services			246,423	246,423		246,423	(230,196)	16,227			19
20	Dues, Fees, Subscriptions & Promotions			6,407	6,407		6,407	489	6,896			20
21	Clerical & General Office Expenses	50,513	11,213	101,623	163,349		163,349	124,102	287,451			21
22	Employee Benefits & Payroll Taxes			263,333	263,333		263,333	43,331	306,664			22
23	Inservice Training & Education							109	109			23
24	Travel and Seminar			1,771	1,771		1,771	2,651	4,422			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			248,934	248,934		248,934	961	249,895			26
27	Other (specify):*											27
28	TOTAL General Administration	128,297	11,213	868,491	1,008,001		1,008,001	(58,553)	949,448			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,919,672	276,617	1,201,777	3,398,066		3,398,066	(47,569)	3,350,497			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			38,179	38,179		38,179	16,603	54,782			30
31	Amortization of Pre-Op. & Org.			340	340		340	432	772			31
32	Interest			82,987	82,987		82,987	43,055	126,042			32
33	Real Estate Taxes			26,361	26,361		26,361	7,065	33,426			33
34	Rent-Facility & Grounds			250,000	250,000		250,000	(237,720)	12,280			34
35	Rent-Equipment & Vehicles							2,547	2,547			35
36	Other (specify):*											36
37	TOTAL Ownership			397,867	397,867		397,867	(168,018)	229,849			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,226		50,226		50,226		50,226			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			203,922	203,922		203,922		203,922			42
43	Other (specify):* bad debt			18,565	18,565		18,565	(18,565)				43
44	TOTAL Special Cost Centers		50,226	222,487	272,713		272,713	(18,565)	254,148			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,919,672	326,843	1,822,131	4,068,646		4,068,646	(234,152)	3,834,494			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	(13,396)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	26	2		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	(18,565)	43		24
25	Fund Raising, Advertising and Promotional	(2,250)	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)	\$ (34,185)		\$	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)	(199,967)	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (199,967)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (234,152)		37

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

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

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

ID#0051045

Report Period Beginning:1/1/25

Ending:12/31/25

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Real Estate Taxes	7,065	33	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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16				16
17				17
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19				19
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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	7,065		49

Summary A

12/31/25

[illegible]

Summary B

12/31/25

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
STEVEN BLISKO	100	SEE ATTACHED		Integrity HCC Services	Skokie	Consulting
				Herrin HC Realty LLC	Anna	Propco

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Integrity HCC Services LLC		\$ 2,098	\$ 2,098	1
2	V	6	Maintenance		Integrity HCC Services LLC		8,860	8,860	2
3	V	21	Office		Integrity HCC Services LLC		125,972	125,972	3
4	V	22	Benefits		Integrity HCC Services LLC		43,331	43,331	4
5	V	24	Travel Expense		Integrity HCC Services LLC		2,651	2,651	5
6	V	23	Seminars		Integrity HCC Services LLC		109	109	6
7	V	34	Rent		Integrity HCC Services LLC		12,280	12,280	7
8	V	35	Equipment Lease		Integrity HCC Services LLC		2,547	2,547	8
9	V	19	Professional Fees	240,000	Integrity HCC Services LLC		9,804	(230,196)	9
10	V	32	Interest Expense		Herrin HC Realty LLC		43,055	43,055	10
11	V	26	Insurance expesne		Integrity HCC Services LLC		961	961	11
12	V	31	amortization expense		Herrin HC Realty LLC		432	432	12
13	V	34	Rent	250,000	Herrin HC Realty LLC			(250,000)	13
14	Total			\$ 490,000			\$ 252,100	\$ * (237,900)	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	30	Depreciation expense	\$	Herrin HC Realty LLC		\$ 29,999	\$ 29,999	15
16	V	21	Bank charges		Herrin HC Realty LLC		303	303	16
17	V	20	Dues and Subs		Integrity HCC Services LLC		489	489	17
18	V	21	Annual report		Herrin HC Realty LLC		77	77	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			\$			\$ 30,868	\$ * 30,868	39

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

Ownership Listing-1

1/1/25
12/31/25

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Names of trust beneficiaries must be listed.

1	2
3	4
5	6
7	8
9	10
11	12
13	14
15	16
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23	24
25	26
27	28
29	30
31	32
33	34
35	36
37	38
39	40
41	42
43	44
45	46
47	48
49	50
51	52
53	54
55	56
57	58
59	60
61	62
63	64
65	66
67	68
69	70
71	72
73	74
75	

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1			Integrity HC of Cobden	Cobden				1
2			Integrity HC of Carbondale	Carbondale				2
3			Integrity HC of Marion	Marion				3
4			Integrity HC of Anna	Herrin				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 HERRIN # 0051045 Report Period Beginning: 1/1/25 Ending: 12/31/25

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

Facility Name & ID Number INTEGRITY HC OF HERRIN # 0051045 Report Period Beginning: 1/1/25 Ending: 12/31/25

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	TX/OK Funding LLC		X	Mortgage	VARIOUS	2/12/21	\$ 2,200,000	\$ 1,662,132	2/1/31	5.0000	\$ 43,055	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Ecapital		X	Operations	Various			as needed		Various	82,987	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 2,200,000	\$ 1,662,132			\$ 126,042	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,200,000	\$ 1,662,132			\$ 126,042	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 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 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	(29,732)	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.)				\$	33,426	2
3. Under or (over) accrual (line 2 minus line 1).				\$	63,158	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	(29,732)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	33,426	7
Assessed Value from Real Estate Tax Bill:	2024		8			
Real Estate Tax Bill for Calendar Year:	2020	21,949	9			
	2021	28,338	10			
	2022	29,732	11			
	2023	32,707	12			
	2024	33,426	13			
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME INTEGRITY HC OF HERRIN COUNTY WILIAMSON

FACILITY IDPH LICENSE NUMBER 0051045

CONTACT PERSON REGARDING THIS REPORT Dan Gaafar

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 02-18-452-001	Nursing Facility	\$ 32,612.56	\$ 32,612.56
2. 02-18-452-002	Nursing Facility	\$ 378.60	\$ 378.60
3. 02-18-452-003	Nursing Facility	\$ 159.06	\$ 159.06
4. 02-18-452-004	Nursing Facility	\$ 134.22	\$ 134.22
5. 02-18-452-005	Nursing Facility	\$ 141.32	\$ 141.32
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 33,425.76	\$ 33,425.76

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: q B. General Construction Type: Exterior BRICK Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (X) (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? (X) (a) Own the Equipment (X) (b) Rent equipment from a Related Organization. (X) (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. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? YES
H. Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? NO
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X 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: 340 4. Dates Incurred: 6/1/10

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

See Page 12A, Line 70 for total

XL OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Installation of Emergency call service	2018	\$ 1,879	\$ 48	39	\$ 48	\$	\$ 361	37
38	Mural Work	2018	2,720	70	39	70		524	38
39	Installation of vinyl floor tiles	2018	3,870	99	39	99		744	39
40									40
41	Floor tiles	2019	1,200		39				41
42									42
43									43
44	call light system	2021	15,922	408	39	408		1,836	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)		\$ 1,491,296	\$ 38,207		\$ 38,207	\$	\$ 238,320	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	\$ 69,321	\$ 2,861	\$ 13,864	\$ 11,003	5	\$ 62,329	71
72	Current Year Purchases	27,110	27,110	2,711	(24,399)	5	27,110	72
73	Fully Depreciated Assets	1,099,033					1,099,033	73
74								74
75	TOTALS	\$ 1,195,464	\$ 29,971	\$ 16,575	\$ (13,396)		\$ 1,188,472	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)			\$	2,686,760
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	68,178
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	54,782
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(13,396)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,426,792

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: HERRIN HC REALTY 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	49	2/1/2021	\$ 250,000	32	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		49		\$ 250,000			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 .
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.

10. Effective dates of current rental agreement:
Beginning 02/01/2021
Ending 11/1/2053

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2026	\$ 250,000
13.	/2027	\$ 257,500
14.	/2028	\$ 257,500

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	\$	1,303	\$ 82,113	\$	1,303	\$ 82,113	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		156	11,386		156	11,386	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		1,758	119,543		1,758	119,543	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				32,041		32,041	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): xrays	39-2					1,590		1,590	12
13	Other (specify): labs	39-2					4,182			13
14	TOTAL			\$	3,217	\$ 213,042	\$ 37,813	3,217	\$ 246,673	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.

Facility Name & ID Number INTEGRITY HC OF HERRIN

0051045

Report Period Beginning: 1/1/25

Ending:

12/31/25

XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/25**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,600	\$ 1,600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	411,541	411,541	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):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 413,141	\$ 413,141	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	340,424	340,424	15
16	Equipment, at Historical Cost	203,292	203,292	16
17	Accumulated Depreciation (book methods)	(295,226)	(295,226)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,225	12,225	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,225)	(12,225)	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)	\$ 248,490	\$ 248,490	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 661,631	\$ 661,631	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,290,017	\$ 2,290,017	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,135,984	2,135,984	29
30	Accrued Salaries Payable	126,842	126,842	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,703	9,703	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)	\$ 4,562,546	\$ 4,562,546	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)	\$ 4,562,546	\$ 4,562,546	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,900,915)	\$ (3,900,915)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 661,631	\$ 661,631	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,442,032)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,442,032)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(458,883)	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)	\$ (458,883)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,900,915)	24

* This must agree with page 17, line 47.

Facility Name & ID Number INTEGRITY HC OF HERRIN

0051045

Report Period Beginning: 1/1/25

Ending: 12/31/25

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	\$ 3,499,470	1
2	Discounts and Allowances for all Levels	(288,162)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,211,308	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	354,156	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 354,156	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	44,511	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)	\$ 44,511	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(305)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (305)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	vending	93	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 93	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,609,763	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	662,536	31
32	Health Care	1,727,529	32
33	General Administration	1,008,001	33
	B. Capital Expense		
34	Ownership	397,867	34
	C. Ancillary Expense		
35	Special Cost Centers	50,226	35
36	Provider Participation Fee	203,922	36
	D. Other Expenses (specify):		
37	bad debt	18,565	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,068,646	40
41	Income before Income Taxes (line 30 minus line 40)**	(458,883)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (458,883)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 2,294,128.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	517,440.00	48
49	Medicare Part A	527,486.00	49
50	Other-(specify)	160,416.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,499,470	56

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	712	758	\$ 31,217	\$ 41.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,847	6,235	251,543	40.34	3
4	Licensed Practical Nurses	6,967	7,381	239,889	32.50	4
5	CNAs & Orderlies	27,484	28,958	683,824	23.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,085	1,207	21,094	17.48	9
10	Activity Assistants	5,004	5,189	78,520	15.13	10
11	Social Service Workers	1,653	1,770	30,097	17.00	11
12	Dietician					12
13	Food Service Supervisor	1,983	2,160	42,849	19.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,753	9,052	145,150	16.04	15
16	Dishwashers					16
17	Maintenance Workers	1,794	1,854	38,481	20.76	17
18	Housekeepers	7,725	8,136	129,881	15.96	18
19	Laundry	2,502	2,753	44,770	16.26	19
20	Administrator	1,975	2,186	80,476	36.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,130	2,387	53,275	22.32	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) MDS Coord	1,384	1,449	48,606	33.54	33
34	TOTAL (lines 1 - 33)	76,998	81,475	\$ 1,919,672 *	\$ 23.56	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	\$ 6,992	1-3	35
36	Medical Director	Monthly	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	23,874	10-3	38
39	Pharmacist Consultant	Monthly	4,077	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	5,001	12-3	45
46	Other(specify) MDS	Monthly	18,381	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 70,325		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.

XX. GENERAL INFORMATION:

- (1)

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

NO
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name

HEALTH CARE COUNCIL OF IL (HCCI)

Amount

3,850

3,850

Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)

3,850

Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)

3,850

Total
- (5)

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

\$ 18,169

Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 203,922

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

Indicate the amount.

\$ N/A
- (12)

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?

YES

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

YES

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
- (13)

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

Firm Name: N/A

NO
- (14)

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

YES
- (15)

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.

NO

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