

		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: 0050997

Facility Name: INTEGRITY HC OF MARION

Address: 1301 EAST DEYOUNG MARION 62959

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.

X

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

(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 MARION # 0050997 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 <u>125</u>					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>125</u>	Skilled (SNF)	<u>125</u>	<u>45,625</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>125</u>	TOTALS	<u>125</u>	<u>45,625</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	6,510	16,582	3,789	203	4,416	3,084	2,716	37,300	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,510	16,582	3,789	203	4,416	3,084	2,716	37,300	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 81.75%

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 125

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED 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.

Facility Name & ID Number **INTEGRITY HC OF MARION** # **0050997** 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	282,787	33,793	10,863	327,443		327,443		327,443			1
2	Food Purchase		350,358		350,358		350,358	26	350,384			2
3	Housekeeping	225,501	19,178		244,679		244,679		244,679			3
4	Laundry	46,405	15,100		61,505		61,505		61,505			4
5	Heat and Other Utilities			132,735	132,735		132,735	2,623	135,358			5
6	Maintenance	110,150	89,272		199,422		199,422	11,075	210,497			6
7	Other (specify):*											7
8	TOTAL General Services	664,843	507,701	143,598	1,316,142		1,316,142	13,724	1,329,866			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	3,604,290	216,323	42,087	3,862,700		3,862,700		3,862,700			10
10a	Therapy			537,485	537,485		537,485		537,485			10a
11	Activities	103,432	5,412		108,844		108,844		108,844			11
12	Social Services	71,218	6,374		77,592		77,592		77,592			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* RX Consultant			11,340	11,340		11,340		11,340			15
16	TOTAL Health Care and Programs	3,778,940	228,109	614,912	4,621,961		4,621,961		4,621,961			16
	C. General Administration											
17	Administrative	110,275			110,275		110,275		110,275			17
18	Directors Fees											18
19	Professional Services			309,424	309,424		309,424	(281,846)	27,578			19
20	Dues, Fees, Subscriptions & Promotions			6,729	6,729		6,729	611	7,340			20
21	Clerical & General Office Expenses	99,419	23,404	200,422	323,245		323,245	107,753	430,998			21
22	Employee Benefits & Payroll Taxes			665,961	665,961		665,961	54,164	720,125			22
23	Inservice Training & Education							136	136			23
24	Travel and Seminar			3,753	3,753		3,753	3,314	7,067			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			321,220	321,220		321,220	62,996	384,216			26
27	Other (specify):*											27
28	TOTAL General Administration	209,694	23,404	1,507,509	1,740,607		1,740,607	(52,872)	1,687,735			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,653,477	759,214	2,266,019	7,678,710		7,678,710	(39,148)	7,639,562			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			231,374	231,374		231,374	168,358	399,732			30
31	Amortization of Pre-Op. & Org.			340	340		340	11,873	12,213			31
32	Interest			7,833	7,833		7,833	206,416	214,249			32
33	Real Estate Taxes			141,162	141,162		141,162	(39,635)	101,527			33
34	Rent-Facility & Grounds			866,000	866,000		866,000	(850,650)	15,350			34
35	Rent-Equipment & Vehicles							3,184	3,184			35
36	Other (specify):* replacement tax			18,080	18,080		18,080	(18,080)				36
37	TOTAL Ownership			1,264,789	1,264,789		1,264,789	(518,534)	746,255			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		189,084		189,084		189,084		189,084			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			658,695	658,695		658,695		658,695			42
43	Other (specify):* bad debt exp			47,908	47,908		47,908	(47,908)				43
44	TOTAL Special Cost Centers		189,084	706,603	895,687		895,687	(47,908)	847,779			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,653,477	948,298	4,237,411	9,839,186		9,839,186	(605,590)	9,233,596			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	(35,579)	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	(47,908)	43		24
25	Fund Raising, Advertising and Promotional	(50,383)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(18,080)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (151,924)		\$	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)	(453,666)	various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (453,666)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (605,590)		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#0050997

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				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

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 Service	Skokie	Consulting
				Marion HC Realty LL	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		\$ 2,623	\$ 2,623	1
2	V	6	Maintenance		Integrity HCC Services LLC		11,075	11,075	2
3	V	21	Office		Integrity HCC Services LLC		157,465	157,465	3
4	V	22	Benefits		Integrity HCC Services LLC		54,164	54,164	4
5	V	24	Travel Expense		Integrity HCC Services LLC		3,314	3,314	5
6	V	23	Seminars		Integrity HCC Services LLC		136	136	6
7	V	34	Rent		Integrity HCC Services LLC		15,350	15,350	7
8	V	35	Equipment Lease		Integrity HCC Services LLC		3,184	3,184	8
9	V	19	Professional Fees	300,000	Integrity HCC Services LLC		12,254	(287,746)	9
10	V	32	Interest Expense		Marion HC Realty LLC		206,416	206,416	10
11	V	33	property tax expense	141,162	Marion HC Realty LLC		101,527	(39,635)	11
12	V	31	amortization expense		Marion HC Realty LLC		11,873	11,873	12
13	V	34	Rent	866,000	Marion HC Realty LLC			(866,000)	13
14	Total			\$ 1,307,162			\$ 579,381	\$ * (727,781)	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	30	Depreciation expense	\$	Marion HC Realty LLC		\$ 203,937	\$ 203,937	15
16	V	21	Bank charges		Marion HC Realty LLC		594	594	16
17	V	19	Audit costs		Marion HC Realty LLC		5,900	5,900	17
18	V	21	Annual report		Marion HC Realty LLC		77	77	18
19	V	20	Dues and subs		Integrity HCC Services LLC		611	611	19
20	V	26	Insurance		Marion HC Realty LLC		61,795	61,795	20
21	V	26	Insurance		Integrity HCC Services LLC		1,201	1,201	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			\$			\$ 274,115	\$ * 274,115	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 related nursing homes and related organizations (parties) as defined in the instructions.

	1		2		3			
	RELATED NURSING HOMES		RELATED NURSING HOMES		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 Anna	Anna				3
4			Integrity HC of Herrin	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 MARION # 0050997 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 MARION # 0050997 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	HUD		X	Mortgage	VARIOUS	11/16/21	\$ 7,840,600	\$ 7,097,237	11/1/51	2.3900	\$ 172,153	1	
2	TX/OK Funding LLC		X	Mortgage	VARIOUS	2/12/21	1,750,737	897,354	9/1/31	5.0000	34,263	2	
3												3	
4												4	
5												5	
	Working Capital												
6	ECAPITAL		X	Operations	VARIOUS			as needed	4/1/27	various	7,833	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 9,591,337	\$ 7,994,591			\$ 214,249	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 9,591,337	\$ 7,994,591			\$ 214,249	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 39,528 Line # 26

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 report.			\$	108,998	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.)			\$	101,527	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(7,471)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	108,998	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.			\$	101,527	7
Assessed Value from Real Estate Tax Bill: 2024 8					
Real Estate Tax Bill for Calendar Year: 2020 60,719 9					
2021 62,272 10					
2022 85,635 11					
2023 101,728 12					
2024 101,527 13					
		14	FOR BHF USE ONLY		
		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 MARION COUNTY WILLIAMSON

FACILITY IDPH LICENSE NUMBER 0050997

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)
				<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.	05-29-03-983-A	Nursing Facility	\$ 101,527.16	\$ 101,527.16
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 101,527.16	\$ 101,527.16

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: 16,500 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

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

See Page 12A, Line 70 for total

Facility Name & ID Number INTEGRITY HC OF MARION

0050997

Report Period Beginning:

1/1/25

Ending:

12/31/25

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Resident rooms: door handles, ceiling tiles, paint, flooring,	2011	\$	\$		\$	\$	\$	37
38	lighting fixtures	2011	138,348	3,697	39	3,697		52,032	38
39	Corridors: handrails, signs, doors, ceiling tiles, lighting	2011	130,900	3,356	39	3,356		48,663	39
40	Windows and painting of laundry room	2011	3,300	85	39	85		1,231	40
41	HVACs	2011	32,400	831	39	831		12,049	41
42	Landscaping	2011	12,500	321	39	321		4,653	42
43	Drainage	2011	4,600	118	39	118		1,711	43
44	Custom laminate nurses station	2011	16,900	433	39	433		6,280	44
45	Restrooms: molding, chair rail, door, tile, paint, toliets, mirror	2011	22,000	564	39	564		8,178	45
46	Whirlpool Tub, plumbing, wall tiles	2011	12,000	308	39	308		4,465	46
47	Shower room: door, tile, paint, shower stalls, bathtub, lights	2011	55,000	1,410	39	1,410		20,446	47
48	Patio: concrete, doors, drainage	2011	41,600	1,067	39	1,067		15,470	48
49	Dining: molding, chair rail, ceiling tiles, wallcovering, signs	2011	50,535	1,296	39	1,296		18,792	49
50	New doors and walls in medicine storage room	2011	6,000	154	39	154		2,233	50
51	Storage room: new wall, door and paint	2011	5,500	141	39	141		2,045	51
52	Toliets, sinks, mirrors, lighting grab bars in residents bathrooms	2011	30,000	769	39	769		11,151	52
53	Roof	2011	83,000	2,128	39	2,128		30,856	53
54	Toliets, sinks, mirrors, lighting grab bars in residents bathrooms	2011	10,000	256	39	256		3,713	54
55	Call bell system and wander management system	2011	61,000	1,564	39	1,564		22,674	55
56	Med room and MOP: closet door, sink, counter, lighting, paint	2011	5,700	146	39	146		2,117	56
57	Bathroom: flooring, sink, toliet, lighting, grab bars, paint	2011	4,100	105	39	105		1,523	57
58	Concrete patio	2011	6,300	162	39	162		2,348	58
59	Sink room: tile, backsplash, paint, countertops, cabinets	2011	4,000	103	39	103		1,492	59
60	Woodlock kick plates	2011	7,900	203	39	203		2,942	60
61	Refinish nurse station, quartz countertop	2011	5,300	136	39	136		1,972	61
62	Flooring for vestibule	2011	2,300	59	39	59		855	62
63	Seating areas: door, paint, lighting, ceiling tile, drywall, flooring	2011	8,100	208	39	208		3,015	63
64	Water heater and installation	2013	2,836	73	39	73		924	64
65	Wiring for nurse stations and kiosks	2013	20,763	532	39	532		6,561	65
66									66
67	5 ton gas electric rooftop units	2014	10,768		39			10,768	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,500,049	\$ 239,083		\$ 239,083	\$	\$ 1,513,851	70

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

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	
1	Totals from Page 12A, Carried Forward		\$ 7,500,049	\$ 239,083		\$ 239,083	\$	\$ 1,513,851	1
2	Install new Duro-last roofing system	2015	148,950	3,819	39	3,819		39,940	2
3	Build 30 x 40 x 8ft metal barn	2015	15,500	397	39	397		4,754	3
4	309 sq yrds of hot-mix asphalt and pouring	2015	6,475	166	39	166		1,736	4
5	Repair damage to roof	2015	1,383	35	39	35		368	5
6	Troubleshoot and fix wonderguard call bell system	2015	1,575	40	39	40		421	6
7	Repair kitchen drain line, tie in new drains, pour concrete	2015	23,800	610	39	610		6,386	7
8	Labor, parts, excavating, disposal fees to repair water line	2015	3,566	91	39	91		954	8
9									9
10									10
11									11
12									12
13	Install 7 rooms nurse call system	2016	2,164	55	39	55		521	13
14	Gas / electric 4 ton rooftop	2016	5,959	153	39	153		1,447	14
15	Redo rear parking lot (fix sinkhole)	2016	2,100	54	39	54		510	15
16									16
17	New mixing valve	2017	7,724	198	39	198		1,683	17
18	New HVAC	2017	8,282	212	39	212		1,803	18
19	New compressor	2017	3,600	92	39	92		786	19
20									20
21	Replace parking lot lighting	2018	2,195	56	39	56		365	21
22	Remove and replace plumbing and a section of floor tile	2018	6,569	168	39	168		1,093	22
23	Designed, manufacture and install new awning	2018	3,514	91	39	91		904	23
24									24
25	HVAC (2)	2023	62,500	1,250	10	6,250	5,000	65,912	25
26	Paint exterior	2023	35,000	700	10	3,500	2,800	33,904	26
27	Roof Repair	2023	81,880	1,638	10	8,188	6,550	79,315	27
28	Flooring throughout building	2023	34,648	693	10	3,465	2,772	36,540	28
29									29
30	Alarm System	2024	44,997	3,600	5	4,500	900	33,298	30
31	Water heater	2024	11,900	952	5	1,190	238	8,806	31
32	New AC unit	2024	16,131	1,290	5	1,613	323	11,937	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,030,461	\$ 255,443		\$ 274,026	\$ 18,583	\$ 1,847,234	34

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

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	
1	Totals from Page 12B, Carried Forward		\$ 8,030,461	\$ 255,443		\$ 274,026	\$ 18,583	\$ 1,847,234	1
2									2
3									3
4	Install new Washing Machines	2025	25,251	25,251	10	2,525	(22,726)	25,251	4
5	Install new Phone System	2025	9,090	9,090	10	909	(8,181)	9,090	5
6	Install new Wanderguard System	2025	39,911	39,911	10	3,991	(35,920)	39,911	6
7	Install new Nurse Call System	2025	71,658	28,553	10	7,166	(21,387)	28,553	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	TOTAL (lines 1 thru 33)		\$ 8,176,371	\$ 358,248		\$ 288,617	\$ (69,631)	\$ 1,950,039	34

**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	\$ 135,795	\$ 5,432	\$ 27,159	\$ 21,727	5	\$ 122,216	71
72	Current Year Purchases	71,632	71,632	14,326	(57,306)	5	71,632	72
73	Fully Depreciated Assets	3,739,134				5	3,739,134	73
74								74
75	TOTALS	\$ 3,946,561	\$ 77,064	\$ 41,485	\$ (35,579)		\$ 3,932,982	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1	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)	\$ 12,122,932	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 435,312	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 399,732	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (35,579)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,883,021	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: MARION HC REALTY LLC
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO
- If NO, see instructions.

		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	68	2/1/2021	\$ 866,000	32	N/A	3
4	Additions	2001	57					4
5								5
6								6
7	TOTAL		125		\$ 866,000			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

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.	12/31/2026	\$ 866,000
13.	12/31/2027	\$ 891,980
14.	12/31/2028	\$ 891,980

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	\$	1,133	\$ 226,512	\$	1,133	\$ 226,512	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		141	68,483		141	68,483	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-3	hrs		1,506	242,490		1,506	242,490	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				159,996		159,996	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Xrays</u>	39-2					8,636		8,636	12
13	Other (specify): <u>Labs</u>	39-2					20,452		20,452	13
14	TOTAL			\$	2,780	\$ 537,485	\$ 189,084	2,780	\$ 726,569	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,000	\$ 1,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	6,145,375	6,145,375	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): <u>replace reserve</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,146,375	\$ 6,146,375	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	2,046,889	2,046,889	15
16	Equipment, at Historical Cost	821,561	821,561	16
17	Accumulated Depreciation (book methods)	(1,726,060)	(1,726,060)	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)	\$ 1,142,390	\$ 1,142,390	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,288,765	\$ 7,288,765	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,233,221	\$ 2,233,221	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	362,733	362,733	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,026	27,026	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)	\$ 2,622,980	\$ 2,622,980	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)	\$ 2,622,980	\$ 2,622,980	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,965,785	\$ 5,965,785	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,588,765	\$ 8,588,765	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,740,317	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,740,317	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,225,468	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)	\$ 2,225,468	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)	\$ 5,965,785	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number INTEGRITY HC OF MARION

0050997

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	\$ 10,679,474	1
2	Discounts and Allowances for all Levels	(918,460)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,761,014	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,078,717	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,078,717	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	222,084	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)	\$ 222,084	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	71	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 71	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	vending	2,768	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,768	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,064,654	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,740,607	31
32	Health Care	4,621,961	32
33	General Administration	1,316,142	33
	B. Capital Expense		
34	Ownership	1,264,789	34
	C. Ancillary Expense		
35	Special Cost Centers	189,084	35
36	Provider Participation Fee	658,695	36
	D. Other Expenses (specify):		
37	bad debt expense	47,908	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,839,186	40
41	Income before Income Taxes (line 30 minus line 40)**	2,225,468	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,225,468	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 5,996,063.00	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	798,024.00	48
49	Medicare Part A	2,050,181.00	49
50	Other-(specify) Commerical Insurance	1,835,206.00	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)	\$ 10,679,474	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	1,381	1,429	\$ 65,124	\$ 45.57	1
2	Assistant Director of Nursing	595	619	23,920	38.64	2
3	Registered Nurses	15,884	16,787	655,876	39.07	3
4	Licensed Practical Nurses	23,495	25,079	844,546	33.68	4
5	CNAs & Orderlies	82,351	86,920	1,893,803	21.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,299	2,463	46,966	19.07	9
10	Activity Assistants	4,899	4,616	78,856	17.08	10
11	Social Service Workers	3,599	3,777	64,121	16.98	11
12	Dietician					12
13	Food Service Supervisor	1,137	1,207	25,343	21.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,819	14,377	232,249	16.15	15
16	Dishwashers					16
17	Maintenance Workers	1,691	1,762	39,794	22.58	17
18	Housekeepers	12,231	13,132	215,436	16.41	18
19	Laundry	6,181	6,428	100,318	15.61	19
20	Administrator	2,173	2,332	103,149	44.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,869	2,041	52,810	25.87	23
24	Clerical	3,548	3,909	84,724	21.67	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	1,847	1,997	33,706	16.88	31
32	Other Health C: Nurse Consult	236	244	11,852	48.57	32
33	Other(specify) MDS Coord	1,822	2,020	80,884	40.04	33
34	TOTAL (lines 1 - 33)	181,057	191,139	\$ 4,653,477 *	\$ 24.35	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	\$ 10,863	1-3	35
36	Medical Director	Monthly	24,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	22,632	10-3	38
39	Pharmacist Consultant	Monthly	11,340	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	6,374	12-3	45
46	Other(specify) MDS	Monthly	19,455	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 94,664		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.

STATE OF ILLINOIS

Facility Name & ID NumberINTEGRITY HC OF MARION# 0050997Report Period Beginning: 1/1/25Ending: 12/31/25Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Tina Melia	administrator	0	\$ 74,788
Caitlin Skaggs	administrator	0	35,487
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 110,275

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Integrity HCC Services	Consulting Fees	\$ 300,000
Bradley and Associates	Accounting fees	6,000
Tax Opportunities of America	Accounting fees	1,266
Daniel Maher	Legal fees	40
Gutniki LP	Legal fees	2,118
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 309,424

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 112,920
Unemployment Compensation Insurance	
FICA Taxes	422,719
Employee Health Insurance	124,001
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other employee benefits	60,485
TOTAL (agree to Schedule V, line 22, col.8)	

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,991
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	4,200
Other Fees	611
Dues and Subscriptions	238
Greater Marion Chamber of Commerce	300
Less: Public Relations Expense	()
PAC and Lobbying payments	()
All non-allowable advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Travel Reimbursement	1,650
Allocated travel	1,481
Other Travel	3,936
Seminar Expense	
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 7,067

* Attach copy of IMRF notifications

**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

Amount

HEALTH CARE COUNCIL OF IL (HCCI)

4,200

4,200 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)

Total
- (4)

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

HEALTH CARE COUNCIL OF IL (HCCI)

4,200

4,200 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.

\$

658,695

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.