

Facility Name & ID Number INTEGRITY HC OF COLUMBIA

0051381 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 N/A

	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	119	Skilled (SNF)	119	43,435	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	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	16,083	9,937	4,981	31,001	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,083	9,937	4,981	31,001	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.37%

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)
N/A

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 04/01/11

J. Was the facility purchased or leased after January 1, 1978?
YES Date 04/01/11 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 119 and days of care provided 4,899

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **INTEGRITY HC OF COLUMBIA** # **0051381** Report Period Beginning: **01/01/18** Ending: **12/31/18**

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	216,444	11,782	7,336	235,562		235,562		235,562		1
2	Food Purchase		181,171		181,171		181,171		181,171		2
3	Housekeeping	149,515	14,230		163,745		163,745		163,745		3
4	Laundry	54,628	15,910		70,538		70,538		70,538		4
5	Heat and Other Utilities			151,941	151,941		151,941	1,601	153,542		5
6	Maintenance	89,102	17,958	46,020	153,080		153,080	270	153,350		6
7	Other (specify):*										7
8	TOTAL General Services	509,689	241,051	205,297	956,037		956,037	1,871	957,908		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,754,471	100,359	37,063	1,891,893		1,891,893	(3,378)	1,888,515		10
10a	Therapy			885,617	885,617		885,617		885,617		10a
11	Activities	66,504	5,497		72,001		72,001		72,001		11
12	Social Services	69,296		4,403	73,699		73,699		73,699		12
13	CNA Training										13
14	Program Transportation			78	78		78		78		14
15	Other (specify):* Pharmacy Consultant			8,937	8,937		8,937		8,937		15
16	TOTAL Health Care and Programs	1,890,271	105,856	960,098	2,956,225		2,956,225	(3,378)	2,952,847		16
	C. General Administration										
17	Administrative	92,494			92,494		92,494		92,494		17
18	Directors Fees										18
19	Professional Services			278,553	278,553		278,553	(256,589)	21,964		19
20	Dues, Fees, Subscriptions & Promotions			8,917	8,917		8,917	25	8,942		20
21	Clerical & General Office Expenses	99,816	31,481	81,196	212,493		212,493	178,576	391,069		21
22	Employee Benefits & Payroll Taxes			420,712	420,712		420,712	15,858	436,570		22
23	Inservice Training & Education										23
24	Travel and Seminar			13,007	13,007		13,007	6,450	19,457		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			206,400	206,400		206,400	593	206,993		26
27	Other (specify):*										27
28	TOTAL General Administration	192,310	31,481	1,008,785	1,232,576		1,232,576	(55,087)	1,177,489		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,592,270	378,388	2,174,180	5,144,838		5,144,838	(56,594)	5,088,244		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.

Facility Name & ID Number

INTEGRITY HC OF COLUMBIA

#0051381

Report Period Beginning:

01/01/18

Ending:

12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			51,857	51,857		51,857	(14,511)	37,346			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,441	71,441		71,441	(8,909)	62,532			32
33	Real Estate Taxes			71,447	71,447		71,447		71,447			33
34	Rent-Facility & Grounds			1,024,848	1,024,848		1,024,848	12,725	1,037,573			34
35	Rent-Equipment & Vehicles							1,415	1,415			35
36	Other (specify):* Replacement Tax			9,597	9,597		9,597	(9,597)				36
37	TOTAL Ownership			1,229,190	1,229,190		1,229,190	(18,877)	1,210,313			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,635		143,635		143,635		143,635			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,136	224,136		224,136		224,136			42
43	Other (specify):* Bad Debt			95,854	95,854		95,854	(95,854)				43
44	TOTAL Special Cost Centers		143,635	319,990	463,625		463,625	(95,854)	367,771			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,592,270	522,023	3,723,360	6,837,653		6,837,653	(171,325)	6,666,328			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(14,511)	30		9
10	Interest and Other Investment Income	(8,909)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,378)	10		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,648)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(95,854)	43		24
25	Fund Raising, Advertising and Promotional	(13,732)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,597)	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)	\$ (154,629)		\$	30

BHF USE ONLY							
48		49		50		51	

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	2	
		Amount	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)	(16,696)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (16,696)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (171,325)		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	2	3	4	
		Yes	No	Amount	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		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID# 0051381

Report Period Beginning: 01/01/18

Ending: 12/31/18

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number INTEGRITY HC OF COLUMBIA

0051381

Report Period Beginning:

01/01/18

Ending:

12/31/18

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,601	0	0	0	0	0	0	0	0	0	1,601	5
6	Maintenance	0	270	0	0	0	0	0	0	0	0	0	270	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,871	0	0	0	0	0	0	0	0	0	1,871	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,378)	0	0	0	0	0	0	0	0	0	0	(3,378)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,378)	0	0	0	0	0	0	0	0	0	0	(3,378)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(256,589)	0	0	0	0	0	0	0	0	0	(256,589)	19
20	Fees, Subscriptions & Promotions	0	25	0	0	0	0	0	0	0	0	0	25	20
21	Clerical & General Office Expenses	(22,380)	200,956	0	0	0	0	0	0	0	0	0	178,576	21
22	Employee Benefits & Payroll Taxes	0	15,858	0	0	0	0	0	0	0	0	0	15,858	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,450	0	0	0	0	0	0	0	0	0	6,450	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	593	0	0	0	0	0	0	0	0	0	593	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(22,380)	(32,707)	0	0	0	0	0	0	0	0	0	(55,087)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,758)	(30,836)	0	0	0	0	0	0	0	0	0	(56,594)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number INTEGRITY HC OF COLUMBIA # 0051381 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(14,511)	0	0	0	0	0	0	0	0	0	0	(14,511) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(8,909)	0	0	0	0	0	0	0	0	0	0	(8,909) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	12,725	0	0	0	0	0	0	0	0	0	12,725 34
35	Rent-Equipment & Vehicles	0	1,415	0	0	0	0	0	0	0	0	0	1,415 35
36	Other (specify):*	(9,597)	0	0	0	0	0	0	0	0	0	0	(9,597) 36
37	TOTAL Ownership	(33,017)	14,140	0	(18,877) 37								
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(95,854)	0	0	0	0	0	0	0	0	0	0	(95,854) 43
44	TOTAL Special Cost Centers	(95,854)	0	0	0	0	0	0	0	0	0	0	(95,854) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(154,629)	(16,696)	0	(171,325) 45								

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
STEVEN BLISKO	60 %	See attached		Senior Healthcare	Skokie	Management Co.
A&F GENERAL PARTNERSHIP	35 %					
TED LERMAN	5 %					

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	5 UTILITIES	\$	Senior Healthcare Management		\$ 1,601	\$ 1,601	1
2	V	6 REPAIRS		Senior Healthcare Management		270	270	2
3	V	19 PROFESSIONAL SERVICES	258,000	Senior Healthcare Management		1,411	(256,589)	3
4	V	20 LICENSES & FEES		Senior Healthcare Management		25	25	4
5	V	21 OFFICE SUPPLIES		Senior Healthcare Management		200,956	200,956	5
6	V	22 EMPLOYEE BENEFITS		Senior Healthcare Management		15,858	15,858	6
7	V	24 TRAVEL / SEMINAR		Senior Healthcare Management		6,450	6,450	7
8	V	26 INSURANCE		Senior Healthcare Management		593	593	8
9	V	34 RENT EXPENSE		Senior Healthcare Management		12,725	12,725	9
10	V	35 EQUIPMENT LEASE		Senior Healthcare Management		1,415	1,415	10
11	V			Senior Healthcare Management				11
12	V			Senior Healthcare Management				12
13	V							13
14	Total		\$ 258,000			\$ 241,304	\$ * (16,696)	14

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

Facility Name & ID Number

INTEGRITY HC OF COLUMBIA

0051381

Report Period Beginning:

01/01/18

Ending:

12/31/18

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			INTEGRITY HC OF ALTON	ALTON				1
2			INTEGRITY HC OF ANNA	ANNA				2
3			INTEGRITY HC OF CARBONDALE	CARBONDALE				3
4			INTEGRITY HC OF COBDEN	COBDEN				4
5			INTEGRITY HC OF MARION	MARION				5
6			INTEGRITY HC OF HERRIN	HERRIN				6
7			INTEGRITY HC OF BELLEVILLE	BELLEVILLE				7
8			INTEGRITY HC OF GODFREY	GODFREY				8
9			INTEGRITY HC OF SMITHTON	SMITHTON				9
10			INTEGRITY HC OF WOOD RIVER	WOOD RIVER				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

Facility Name & ID Number INTEGRITY HC OF COLUMBIA # 0051381 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 COLUMBIA

0051381

Report Period Beginning:

01/01/18

Ending: 12/31/18

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 COLUMBIA

0051381

Report Period Beginning:

01/01/18

Ending:

12/31/18

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6	Bank Leumi		x	Working Capital	None	03/06/18	1,420,000		03/31/19	6.7500	38,972					
7	LTC Funding	x		Working Capital	None	Various	4,500,000		Various	Various	32,469					
8																
9	TOTAL Facility Related						\$ 5,920,000	\$			\$ 71,441					
	B. Non-Facility Related*															
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$ 5,920,000	\$			\$ 71,441					

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

* 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 2017 report.		\$	7,508	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.)		\$	85,772	2
3. Under or (over) accrual (line 2 minus line 1).		\$	78,264	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	(6,817)	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.		\$	71,447	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2013	63,419	8	
	2014	64,031	9	
	2015	64,952	10	
	2016	84,865	11	
	2017	85,772	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2017	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME INTEGRITY HC OF COLUMBIA COUNTY JACKSON

FACILITY IDPH LICENSE NUMBER 0051381

CONTACT PERSON REGARDING THIS REPORT Daniel S. 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 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-17-481-004-000</u>	<u>Long Term Care Property</u>	\$ <u>57,982.10</u>	\$ <u>57,982.10</u>
2. <u>04-17-481-028-000</u>	<u>Long Term Care Property</u>	\$ <u>27,045.16</u>	\$ <u>27,045.16</u>
3. <u>04-17-481-005-000</u>	<u>Long Term Care Property</u>	\$ <u>744.82</u>	\$ <u>744.82</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>85,772.08</u></u>	\$ <u><u>85,772.08</u></u>

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 a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,709 B. General Construction Type: Exterior Brick Frame Concrete / Steel Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column with values 1, 2, 3. Row 3 contains 'TOTALS'.

Facility Name & ID Number INTEGRITY HC OF COLUMBIA

0051381

Report Period Beginning:

01/01/18

Ending:

12/31/18

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sign		2011	2,646		5			2,646	9
10										10
11	Fire Alarm		2013	2,731	70	39	70		385	11
12	Rewiring Nurse Stations and Kiosks		2013	17,798	456	39	456		2,432	12
13										13
14	Shut off and drain sprinkler system		2014	3,287	84	39	84		420	14
15	Service trip for security system		2014	1,895	49	39	49		245	15
16	10 zone conventional fire panel		2014	3,307	85	39	85		425	16
17	New sprinkler heads / pipes / caps		2014	2,352	60	39	60		300	17
18										18
19	Replace A/C, furnace and coil		2015	10,991	282	39	282		975	19
20										20
21	New air compressor		2016	2,744	70	39	70		172	21
22	New sprinkler heads		2016	2,157	55	39	55		136	22
23										23
24	Install new furnace		2017	3,497	90	39	90		135	24
25	New roof		2017	148,475	3,808	39	3,808		5,712	25
26	Water heater unit		2017	3,200	82	39	82		123	26
27	Remodel vestibule,lobby,guest bathrooms,offices, dining room		2017	711,767	18,250	39	18,250		27,375	27
28	Delayed egress		2017	8,387	216	39	216		324	28
29	Call light security system		2017	4,169	108	39	108		162	29
30										30
31	Furnish and install Carrier Gas Furnace		2018	4,048	112	39	112		112	31
32	Call Light system for main nurses station		2018	1,200	15	39	15		15	32
33	Furnish and install AO Smith 100 gallon tank		2018	11,341	145	39	145		145	33
34	PCC kiosk wiring infrastructure		2018	1,473	19	39	19		19	34
35	Renovation		2018	154,767	1,984	39	1,984		1,984	35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	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 HVAC Replacement	2018	\$ 29,831	\$ 382	39	\$ 382	\$	\$ 382	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,132,063	\$ 26,422		\$ 26,422	\$	\$ 44,624	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	\$ 45,144	\$ 6,486	\$ 9,029	\$ 2,543	5	\$ 34,184	71
72	Current Year Purchases	18,949	18,949	1,895	(17,054)	5	18,949	72
73	Fully Depreciated Assets	106,874					106,874	73
74								74
75	TOTALS	\$ 170,967	\$ 25,435	\$ 10,924	\$ (14,511)		\$ 160,007	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,303,030	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,857	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 37,346	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (14,511)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 204,631	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: 253 Bradington Drive, 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:		119	01/01/16	\$ 1,024,848	10		3
4	Additions							4
5								5
6								6
7	TOTAL		119		\$ 1,024,848			7

10. Effective dates of current rental agreement:

Beginning 01/01/16

Ending 01/01/26

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

Fiscal Year Ending Annual Rent

12.	<u>12/31/2019</u>	\$ <u>957,202</u>
13.	<u>12/31/2020</u>	\$ <u>985,918</u>
14.	<u>12/31/2021</u>	\$ <u>1,015,496</u>

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: N/A

(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.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	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	\$	7,590	\$ 418,294	\$	7,590	\$ 418,294	1
2	Licensed Speech and Language Development Therapist	10A - 3	hrs		1,275	86,202		1,275	86,202	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A - 3	hrs		6,335	381,121		6,335	381,121	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 prescripts				124,371		124,371	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Radiology and Lab</u>	39 - 2					19,264		19,264	12
13	Other (specify):									13
14	TOTAL			\$	15,200	\$ 885,617	\$ 143,635	15,200	\$ 1,029,252	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/18**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (99,274)	\$ (99,274)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,377,420	1,377,420	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	105,404	105,404	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Related Party receivable	6,530,000	6,530,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 7,913,550	\$ 7,913,550	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,129,417	1,129,417	15
16	Equipment, at Historical Cost	174,752	174,752	16
17	Accumulated Depreciation (book methods)	(204,631)	(204,631)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,099,538	\$ 1,099,538	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,013,088	\$ 9,013,088	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,320,617	\$ 1,320,617	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,744	186,744	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,287	14,287	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,521,648	\$ 1,521,648	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,521,648	\$ 1,521,648	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,491,440	\$ 7,491,440	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,013,088	\$ 9,013,088	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 7,079,423	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 7,079,423	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	412,017	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)	\$ 412,017	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)	\$ 7,491,440	24 *

* This must agree with page 17, line 47.

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	\$ 6,657,932	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,657,932	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	582,831	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 582,831	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		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)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,907	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,907	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,249,670	30

2			
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	956,037	31
32	Health Care	2,956,225	32
33	General Administration	1,232,576	33
B. Capital Expense			
34	Ownership	1,229,190	34
C. Ancillary Expense			
35	Special Cost Centers	143,635	35
36	Provider Participation Fee	224,136	36
D. Other Expenses (specify):			
37	<u>Bad Debt</u>	95,854	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,837,653	40
41	Income before Income Taxes (line 30 minus line 40)**	412,017	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 412,017	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,408,267	44
45	Private Pay - Net Inpatient Revenue	1,764,555	45
46	Medicare - Net Inpatient Revenue	2,467,824	46
47	Other-(specify)	17,286	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,657,932	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No - cash basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number INTEGRITY HC OF COLUMBIA

0051381

Report Period Beginning: 01/01/18

Ending: 12/31/18

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	1,798	1,914	\$ 72,938	\$ 38.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,531	5,739	224,770	39.17	3
4	Licensed Practical Nurses	17,639	18,895	466,939	24.71	4
5	CNAs & Orderlies	54,776	58,374	855,948	14.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,471	5,781	66,504	11.50	10
11	Social Service Workers	3,152	3,412	69,296	20.31	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,117	16,059	216,444	13.48	15
16	Dishwashers					16
17	Maintenance Workers	4,002	4,303	89,102	20.71	17
18	Housekeepers	13,958	15,037	149,515	9.94	18
19	Laundry	5,360	5,478	54,628	9.97	19
20	Administrator	2,385	2,503	92,494	36.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,776	2,776	58,057	20.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,116	2,214	37,790	17.07	31
32	Other Health C: Admission Coord	2,789	3,014	41,759	13.86	32
33	Other(specify) <u>MDS Coordinator</u>	4,164	4,311	96,085	22.29	33
34	TOTAL (lines 1 - 33)	141,034	149,810	\$ 2,592,269 *	\$ 17.30	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	154	\$ 7,336	1 - 3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	613	21,439	10 - 3	38
39	Pharmacist Consultant	179	8,937	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	126	4,403	12 - 3	45
46	Other(specify) <u>MDS Consultant</u>	446	15,623	10 - 3	46
47	<u>HR / Corp Compliance</u>	328	16,403	10 - 21	47
48	<u>Marketing Consultant</u>	119	5,959	21 - 3	48
49	TOTAL (lines 35 - 48)	1,965	\$ 80,100		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council \$4,200
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,456 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? X YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 224,136
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ None Has any meal income been offset against related costs? None Indicate the amount. \$ 0
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100 %
 - d. Have vehicle usage logs been maintained? N/A
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees