

		FOR BHF USE					

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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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

<p>I. IDPH License ID Number: <u>0034256</u></p> <p>Facility Name: <u>Mason City Area Nursing Home</u></p> <p>Address: <u>520 North Price Avenue, Box #32</u> <u>Mason City</u> <u>62664</u> _____ <small>Number City Zip Code</small></p> <p>County: <u>Mason</u></p> <p>Telephone Number: <u>(217) 482-5022</u> Fax # <u>()</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1989</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td style="width:33%"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Craig Ater</u> Telephone Number: <u>(309) 823-7135</u> Email Address: _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1-01-10</u> to <u>12-31-10</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p align="center">Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td colspan="2">(Type or Print Name) <u>Joyce Conrady</u></td> </tr> <tr> <td></td> <td colspan="2">(Title) _____</td> </tr> </table> <table style="width:100%"> <tr> <td style="width:20%;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td></td> <td colspan="2">(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. & CFO</u></td> </tr> <tr> <td></td> <td colspan="2">(Firm Name & Address) <u>Heritage Operations Group, LLC.</u> _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u></td> <td>Fax # <u>()</u></td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) <u>Joyce Conrady</u>			(Title) _____		Paid Preparer	(Signed) _____	(Date) _____		(Print Name and Title) <u>Craig L. Ater</u> <u>Exec V.P. & CFO</u>			(Firm Name & Address) <u>Heritage Operations Group, LLC.</u> _____			(Telephone) <u>()</u>	Fax # <u>()</u>
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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	(Telephone) <u>()</u>	Fax # <u>()</u>																																												

Facility Name & ID Number Mason City Area Nursing Home

0034256 Report Period Beginning: 1-01-10 Ending: 12-31-10

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 _____

	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	33	Skilled (SNF)	33	12,045	1
2		Skilled Pediatric (SNF/PED)			2
3	33	Intermediate (ICF)	33	12,045	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,315	5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,405	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,780	8,278	2,320	20,378	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		4,730		4,730	12
13	DD 16 OR LESS					13
14	TOTALS	9,780	13,008	2,320	25,108	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.92%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold 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 1989

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided 2,320

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number

Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

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	258,083	13,017		271,100		271,100		271,100		1
2	Food Purchase		145,222		145,222		145,222		145,222		2
3	Housekeeping	85,408	23,156		108,564		108,564		108,564		3
4	Laundry	61,556	12,657		74,213		74,213		74,213		4
5	Heat and Other Utilities			98,734	98,734		98,734		98,734		5
6	Maintenance	70,178	35,382	59,126	164,686		164,686		164,686		6
7	Other (specify):*										7
8	TOTAL General Services	475,225	229,434	157,860	862,519		862,519		862,519		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,293,816	61,048	9,684	1,364,548		1,364,548		1,364,548		10
10a	Therapy		92,413	251,063	343,476	(117,720)	225,756		225,756		10a
11	Activities	64,360	4,366		68,726		68,726		68,726		11
12	Social Services	21,762	144		21,906		21,906		21,906		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,379,938	157,971	269,747	1,807,656	(117,720)	1,689,936		1,689,936		16
	C. General Administration										
17	Administrative	82,505			82,505		82,505		82,505		17
18	Directors Fees										18
19	Professional Services			124,260	124,260		124,260	(4,266)	119,994		19
20	Dues, Fees, Subscriptions & Promotions			55,602	55,602	(36,135)	19,467	(11,466)	8,001		20
21	Clerical & General Office Expenses	221,626	27,508	8,686	257,820		257,820		257,820		21
22	Employee Benefits & Payroll Taxes			480,745	480,745		480,745		480,745		22
23	Inservice Training & Education			4,476	4,476		4,476		4,476		23
24	Travel and Seminar			1,681	1,681		1,681		1,681		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			65,181	65,181		65,181		65,181		26
27	Other (specify):*			8,600	8,600		8,600	(7,000)	1,600		27
28	TOTAL General Administration	304,131	27,508	749,231	1,080,870	(36,135)	1,044,735	(22,732)	1,022,003		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,159,294	414,913	1,176,838	3,751,045	(153,855)	3,597,190	(22,732)	3,574,458		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

Mason City Area Nursing Home

#0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

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			124,791	124,791		124,791		124,791			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			1,800	1,800		1,800	(1,800)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,108	3,108		3,108		3,108			35
36	Other (specify):*											36
37	TOTAL Ownership			129,699	129,699		129,699	(1,800)	127,899			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					117,720	117,720		117,720			39
40	Barber and Beauty Shops			12,379	12,379		12,379		12,379			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					36,135	36,135		36,135			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			12,379	12,379	153,855	166,234		166,234			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,159,294	414,913	1,318,916	3,893,123		3,893,123	(24,532)	3,868,591			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

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		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	(1,800)	33		15
16	Personal Expenses (Including Transportation)		23		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties				18
19	Entertainment		24		19
20	Contributions	(1,000)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,266)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(11,466)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (24,532)		\$	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	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)	\$ (24,532)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Mason City Area Nursing Home

ID# 0034256

Report Period Beginning: 1-01-10

Ending: 12-31-10

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1		\$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		(1,800)	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		(1,000)	27	20
21				21
22		(4,266)	19	22
23				23
24		(6,000)	27	24
25		(11,466)	20	25
26				26
27				27
28				28
29		0	33	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	(24,532)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

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	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	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	(4,266)	0	0	0	0	0	0	0	0	0	0	(4,266)	19
20	Fees, Subscriptions & Promotions	(11,466)	0	0	0	0	0	0	0	0	0	0	(11,466)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(7,000)	0	0	0	0	0	0	0	0	0	0	(7,000)	27
28	TOTAL General Administration	(22,732)	0	0	0	0	0	0	0	0	0	0	(22,732)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(22,732)	0	0	0	0	0	0	0	0	0	0	(22,732)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0 32
33	Real Estate Taxes	(1,800)	0	0	0	0	0	0	0	0	0	0	(1,800) 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(1,800)	0	0	0	0	0	0	0	0	0	0	(1,800) 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):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(24,532)	0	0	0	0	0	0	0	0	0	0	(24,532) 45

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
None						

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		\$				\$	1
2	V				0.00%			2
3	V							3
4	V				0.00%			4
5	V							5
6	V				0.00%			6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$				\$ *	14

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

Facility Name & ID Number

Mason City Area Nursing Home

#

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

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	attached								\$		1
2											2
3									0	line 18	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 Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending: 12-31-10

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 Heritage Operations Group
 Street Address box 3188
 City / State / Zip Code Bloomington, IL 61701
 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 Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

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		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						\$				\$								
2																		
3																		
4																		
5																		
Working Capital																		
6																		
7																		
8																		
9	TOTAL Facility Related					\$	\$			\$								
B. Non-Facility Related*																		
10	Interest Income																	
11	Allocated Corporate																	
12																		
13																		
14	TOTAL Non-Facility Related					\$	\$			\$								
15	TOTALS (line 9+line14)					\$	\$			\$								

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

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

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

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

B. Real Estate Taxes

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 2009 report.		\$	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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	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.		\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	\$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mason City Area Nursing Home COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0034256

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,102 B. General Construction Type: Exterior brick Frame wood 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.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ 36,000	1
2					2
3	TOTALS			\$ 36,000	3

Facility Name & ID Number Mason City Area Nursing Home# 0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	97				\$ 2,605,181	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1990 Improvements		1990		7,990						9
10	1991 Improvements		1991		16,512						10
11	1992 Improvements		1992		22,678						11
12	1993 Improvements		1993								12
13	1994 Improvements		1994		24,788						13
14	1995 Improvements		1995		17,777						14
15											15
16	Water Heater		1997		4,800						16
17	Asphalt Sealer		1997		5,395						17
18	Entrance & Walkway		1997		1,700						18
19	Landscaping		1997		6,770						19
20											20
21	Kitch Central A/C		1996		15,800						21
22	Central A/C Administrative Offices		1996		2,500						22
23	Landscapping		1996		2,710						23
24	Automatic Door Closers		1996		3,732						24
25											25
26	Life Safety Alarm		1998		992						26
27	Sound System Cafeteria		1998		1,442						27
28	Security System		1998		10,742						28
29											29
30	Parking Lot Paving		1999		4,190						30
31	Petroleum tank		1999		12,500						31
32											32
33											33
34	C/O Allocation					103,462		103,462		1,762,469	34
35	Book Depreciation										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

Facility Name & ID Number Mason City Area Nursing Home# 0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	Firewalls---ceiling	2000	\$ 10,800	\$		\$	\$	37	
38	Facility Remodel--Materials (Carpeting)	2000	16,156					38	
39								39	
40	Wallpaper	2001	5,552					40	
41	Carpet Installation	2001	4,141					41	
42	Woodwork Refinishing	2001	418					42	
43	Water Heater	2001	6,125					43	
44	Facility Remodel--Labor	2001	1,520					44	
45	Parking Lot	2001	9,375					45	
46	Living room Remodel	2001	415					46	
47	Facility Remodel--Materials	2001	23,795					47	
48	Ceramic Tile Shower	2001	698					48	
49	Hot Water Pump	2001	2,586					49	
50	Carpeting and Installation	2001	2,208					50	
51	Wander Guard	2001	1,270					51	
52	Light Fixtures and Door	2001	2,777					52	
53	Flooring	2001	1,311					53	
54								54	
55	Painting	2002	1,500					55	
56	Remodel & Update Nurses Station	2002	13,224					56	
57	Decorative consulting	2002						57	
58	Living room Remodel	2002						58	
59								59	
60	Remodel & Update Nurses Station	2003	13,262					60	
61	Roof	2003	10,085					61	
62	Window Treatments	2003	1,484					62	
63	Water Heater	2003	6,355					63	
64	Heater/Air Conditioning Unit	2003	1,095					64	
65	Rim Device	2003	1,290					65	
66	Drywall	2003	2,817					66	
67	Flooring							67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)		\$ 2,908,458	\$ 103,462		\$ 103,462	\$	\$ 1,762,469	70

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

Facility Name & ID Number Mason City Area Nursing Home# 0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-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	
1		\$ 2,908,458	\$ 103,462		\$ 103,462	\$	\$ 1,762,469	1
2								2
3	2004	1,392						3
4	2004	21,245						4
5								5
6	2005	2,106						6
7	2005	2,059						7
8	2005	3,732						8
9	2005	21,715						9
10	2005	2,267						10
11								11
12	2006							12
13	2006							13
14	2006	3,794						14
15								15
16								16
17	2007	3,133						17
18	2006	9,000						18
19	2007							19
20	2007	22,541						20
21	2007	7,520						21
22	2007	4,569						22
23								23
24	2008	4,852						24
25	2008	8,116						25
26	2008	2,540						26
27	2008	2,832						27
28	2008	3,522						28
29	2008	3,565						29
30								30
31								31
32								32
33								33
34		\$ 3,038,958	\$ 103,462		\$ 103,462	\$	\$ 1,762,469	34

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

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1		\$ 3,038,958	\$ 103,462		\$ 103,462	\$	\$ 1,762,469	1
2								2
3	2009	18,938						3
4	2009	45,930						4
5	2009	6,135						5
6	2009	5,263						6
7	2009	3,779						7
8	2009	6,975						8
9	2009	3,443						9
10								10
11	2010	9,777						11
12	2010	7,973						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		\$ 3,147,171	\$ 103,462		\$ 103,462	\$	\$ 1,762,469	34

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

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	
1		\$ 3,147,171	\$ 103,462		\$ 103,462	\$	\$ 1,762,469	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	TOTAL (lines 1 thru 33)	\$ 3,147,171	\$ 103,462		\$ 103,462	\$	\$ 1,762,469	34

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

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ <u>634,557</u>	\$ <u>21,329</u>	\$ <u>21,329</u>	\$		\$ <u>567,202</u>	71
72	Current Year Purchases	<u>3,195</u>						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ <u>637,752</u>	\$ <u>21,329</u>	\$ <u>21,329</u>	\$		\$ <u>567,202</u>	75

D. Vehicle Depreciation (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		<u>2008 Chevy Van</u>	<u>2005</u>	\$	\$	\$	\$		\$	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)	\$ <u>3,820,923</u>	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ <u>124,791</u>	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ <u>124,791</u>	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ <u>2,329,671</u>	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.

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning: 1-01-10

Ending: 12-31-10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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 _____.

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? _____

16. Rental Amount for movable equipment: \$ 3,108 Description: _____ YES NO

(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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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?</p> <p><input type="checkbox"/> YES <input 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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2 Staff		3 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	4					
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 87,361	\$		\$ 87,361	1
2	Licensed Speech and Language Development Therapist		hrs			35,693			35,693	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			102,702	0		102,702	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				92,413		92,413	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					25,307			25,307	13
14	TOTAL			\$		\$ 251,063	\$ 92,413		\$ 343,476	14

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

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning: 1-01-10

Ending:

12-31-10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 691,332	\$	1
2	Cash-Patient Deposits	10,789		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	164,658		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,135		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 922,914	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	83,500		13
14	Buildings, at Historical Cost	3,246,784		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	636,552		16
17	Accumulated Depreciation (book methods)	(2,342,171)		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)	\$ 1,624,665	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,547,579	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 86,116	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,789		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	215,841		30
31	Accrued Taxes Payable (excluding real estate taxes)	600		31
32	Accrued Real Estate Taxes(Sch.IX-B)	2,380		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)	\$ 315,726	\$	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)	\$ 315,726	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,231,853	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,547,579	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,398,791	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,398,791	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(166,938)	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)	\$ (166,938)	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)	\$ 2,231,853	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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,698,448	1
2	Discounts and Allowances for all Levels	(840,566)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,857,882	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	623,025	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 623,025	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	14,021	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	205,155	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)	\$ 219,176	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	10,252	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,252	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other</u>	15,850	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,850	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,726,185	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	862,519	31
32	Health Care	1,807,656	32
33	General Administration	1,080,870	33
B. Capital Expense			
34	Ownership	129,699	34
C. Ancillary Expense			
35	Special Cost Centers	12,379	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,893,123	40
41	Income before Income Taxes (line 30 minus line 40)**	(166,938)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (166,938)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Mason City Area Nursing Home

0034256

Report Period Beginning:

1-01-10

Ending:

12-31-10

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	1,882	2,080	\$ 70,138	\$ 33.72	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,397	5,799	168,057	28.98	3
4	Licensed Practical Nurses	19,126	20,323	400,169	19.69	4
5	CNAs & Orderlies	46,654	49,647	565,419	11.39	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,933	5,728	90,033	15.72	8
9	Activity Director					9
10	Activity Assistants	5,786	6,218	64,360	10.35	10
11	Social Service Workers	2,031	2,087	21,762	10.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,345	22,802	258,083	11.32	15
16	Dishwashers					16
17	Maintenance Workers	5,127	5,287	70,178	13.27	17
18	Housekeepers	7,581	7,878	85,408	10.84	18
19	Laundry	6,063	6,366	61,556	9.67	19
20	Administrator	1,900	2,080	82,505	39.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,264	10,171	221,626	21.79	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	137,089	146,466	\$ 2,159,294 *	\$ 14.74	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	\$ 0		35
36	Medical Director	9,000		36
37	Medical Records Consultant	8,030		37
38	Nurse Consultant			38
39	Pharmacist Consultant	0		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	0		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 17,030		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0	50
51	Licensed Practical Nurses	0	0	51
52	Certified Nurse Assistants/Aides	0	0	52
53	TOTAL (lines 50 - 52)		\$	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Joyce Conrady			\$ 82,505	Workers' Compensation Insurance	\$ 42,243	IDPH License Fee	\$ 0	
				Unemployment Compensation Insurance	3,624	Advertising: Employee Recruitment	214	
				FICA Taxes	165,186	Health Care Worker Background Check (Indicate # of checks performed)	978	
				Employee Health Insurance	218,637	Patient Background Checks		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*				
					24		7,773	
				Other Benefits	51,031	Dues & Subscriptions	5,746	
						License & Fees	1,063	
						Less: Public Relations Expense	(7,773)	
						Non-allowable advertising	(0)	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 82,505	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 480,745		\$ 8,001		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
								0
								79
							Seminar Expense	1,602
								0
							Central Office	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,681	
C. Professional Services								
Vendor/Payee	Type	Amount						
Heritage Operations Group	Mgt Fee	\$ 108,000						
Abbott & Co	Audit	7,569						
National Retirement	401K	4,425						
Legal adj to Zero		4,266						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 124,260					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning: 1-01-10

Ending: 12-31-10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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 Health Care Association
- (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? _____
- (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? _____
- (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? 7yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 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. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,135
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? yes
- (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? yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 32,462
- (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. \$ _____
 - 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: Abbott & Co
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.