		FOR BHF USE					

LL1

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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 38268

Facility Name: Mason City Area Nursing Home

Address: 520 N. Price Ave. PO Box 32 (Number) Mason City (City) 62664 (Zip Code)

County: Mason

Telephone Number: 217-482-5022 **Fax #** ( )

HFS ID Number:

Date of Initial License for Current Owners: 1989

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501

In the event there are further questions about this report, please contact:
Name: David M Underwood **Telephone Number:** 309823-7135
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) David M Underwood
(Title) EVP/CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	66	Skilled (SNF)	66	24,090	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,845	8,194	1,317	19,356	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		5,248		5,248	12
13	DD 16 OR LESS					13
14	TOTALS	9,845	13,442	1,317	24,604	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.49%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

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 [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 66 and days of care provided 1,317

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] 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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	258,348	19,639		277,987		277,987		277,987			1
2	Food Purchase		200,509		200,509		200,509		200,509			2
3	Housekeeping	93,810	26,592		120,402		120,402		120,402			3
4	Laundry	74,292	7,386		81,678		81,678		81,678			4
5	Heat and Other Utilities			76,644	76,644		76,644		76,644			5
6	Maintenance	76,946	61,374	103,070	241,390		241,390	(1,250)	240,140			6
7	Other (specify):*											7
8	TOTAL General Services	503,396	315,500	179,714	998,610		998,610	(1,250)	997,360			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,501,112	86,791	100,578	1,688,481		1,688,481		1,688,481			10
10a	Therapy		98,997	15,647	114,644	(112,472)	2,172		2,172			10a
11	Activities	71,056	4,611		75,667		75,667		75,667			11
12	Social Services	29,656		3,482	33,138		33,138		33,138			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,601,824	190,399	128,707	1,920,930	(112,472)	1,808,458		1,808,458			16
	C. General Administration											
17	Administrative	83,598			83,598		83,598		83,598			17
18	Directors Fees											18
19	Professional Services			159,563	159,563		159,563	(1,667)	157,896			19
20	Dues, Fees, Subscriptions & Promotions			179,967	179,967	(148,818)	31,149	(20,441)	10,708			20
21	Clerical & General Office Expenses	185,693	17,099	12,320	215,112		215,112		215,112			21
22	Employee Benefits & Payroll Taxes			479,637	479,637		479,637		479,637			22
23	Inservice Training & Education			2,569	2,569		2,569		2,569			23
24	Travel and Seminar			4,213	4,213		4,213		4,213			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,239	72,239		72,239		72,239			26
27	Other (specify):* Lost Items - Residents			37,232	37,232		37,232	(37,000)	232			27
28	TOTAL General Administration	269,291	17,099	947,740	1,234,130	(148,818)	1,085,312	(59,108)	1,026,204			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,374,511	522,998	1,256,161	4,153,670	(261,290)	3,892,380	(60,358)	3,832,022			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 #38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			251,667	251,667		251,667		251,667			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,538	3,538		3,538	(3,538)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,265	5,265		5,265		5,265			35
36	Other (specify):*											36
37	**TOTAL Ownership**			260,470	260,470		260,470	(3,538)	256,932			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			268,281	268,281	112,472	380,753		380,753			39
40	Barber and Beauty Shops			16,539	16,539		16,539		16,539			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					148,818	148,818		148,818			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			284,820	284,820	261,290	546,110		546,110			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,374,511	522,998	1,801,451	4,698,960		4,698,960	(63,896)	4,635,064			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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,250)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,538)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,667)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,000)			24
25	Fund Raising, Advertising and Promotional	(20,441)			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)**	$ (63,896)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (63,896)		37

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

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

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

Mason City Area Nursing Home

ID# 38268

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	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		0	30	22
23		(1,667)	19	23
24		(37,000)	27	24
25		(20,441)	20	25
26		0	24	26
27		(1,250)	6	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	(60,358)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	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)	
	A. General Services													
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	(1,250)	0	0	0	0	0	0	0	0	0	0	(1,250)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,250)	0	0	0	0	0	0	0	0	0	0	(1,250)	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	(1,667)	0	0	0	0	0	0	0	0	0	0	(1,667)	19
20	Fees, Subscriptions & Promotions	(20,441)	0	0	0	0	0	0	0	0	0	0	(20,441)	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):*	(37,000)	0	0	0	0	0	0	0	0	0	0	(37,000)	27
28	**TOTAL General Administration**	(59,108)	0	0	0	0	0	0	0	0	0	0	(59,108)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(60,358)	0	0	0	0	0	0	0	0	0	0	(60,358)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Capital Expense D. Ownership	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)	
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	(3,538)	0	0	0	0	0	0	0	0	0	0	(3,538)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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	(3,538)	0	0	0	0	0	0	0	0	0	0	(3,538)	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)	(63,896)	0	0	0	0	0	0	0	0	0	0	(63,896)	45

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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
Board of Directors List Attached						
(Not for profit Board-No individual						
ownership)						

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 [x] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Board Members are not compensated								$		1
2	for their services										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 Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 [x]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mason City National Bank		x	Renovation - Paid In Full 2018			$	$			$ 3,538	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 3,538	9
	B. Non-Facility Related*											
10	Interest Income										(3,538)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,538)	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None 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.)

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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 2018 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:			
	2013		8
	2014		9
	2015		10
	2016		11
	2017		12

None - Exempt

	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 Mason City Area Nursing Home COUNTY Mason

FACILITY IDPH LICENSE NUMBER 38268

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 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 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.

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,308 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [x] (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? [x] (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 [x] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1987	$ 26,000	1
2			1999	45,000	2
3	TOTALS			$ 71,000	3

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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											34
35	Book Depreciation					178,208		178,208			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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Firewalls---ceilling	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	$ 178,208		$ 178,208	$	$	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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,908,458	$ 178,208		$ 178,208	$	$	1
2									2
3	Wall Coverings	2004	1,392						3
4	Walkin Cooler/Freezer	2004	21,245						4
5									5
6	Condenser	2005	2,106						6
7	Door Alarm	2005	2,059						7
8	Smoke Alarm	2005	3,732						8
9	Parking lot resurface	2005	21,715						9
10	Fire Alarm	2005	2,267						10
11									11
12	Wallpaper--Business office	2006	845						12
13	Therapy room -- Paint	2006	1,595						13
14	PT & Office Remodel -- carpet	2006	3,794						14
15									15
16									16
17	Furnace	2007	3,133						17
18	Surge Protector	2006	9,000						18
19	Install Carpet - Room 104	2007	582						19
20	Dining Room Paint, carpet	2007	22,541						20
21	Water Heater	2007	7,520						21
22	Pipe Valve	2007	4,569						22
23									23
24	Interior Painting and Design	2008	4,852						24
25	Water Heater	2008	8,116						25
26	AC Condensor	2008	2,540						26
27	A/C Units	2008	2,832						27
28	Carpet - T wing (Sheltered Care)	2008	3,522						28
29	Shower	2008	3,565						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,041,980	$ 178,208		$ 178,208	$	$	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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,041,980	$ 178,208		$ 178,208	$	$	1
2									2
3	Dining Room (Paint, Carpet and fixtures)	2009	18,938						3
4	Sewer Ejection	2009	45,930						4
5	Landscaping	2009	6,135						5
6	Condensor HVAC	2009	5,263						6
7	HVAC units	2009	3,779						7
8	Parking Lot Improvements	2009	6,975						8
9	Shelter Care Wing (paint/wallpaper)	2009	3,443						9
10									10
11	Beauty Shop-- Carpet, Sink, fixtures and Plumbing Labor	2010	9,777						11
12	Parking Lot Improvements	2010	7,973						12
13									13
14	Seal & Stripe Parking Lot	2011	11,040						14
15	A/C condensing unit.	2011	2,573						15
16									16
17	Interior Painting	2012	2,610						17
18									18
19	Lighting Retrofit	2013	5,492						19
20	Water Heaters	2013	18,100						20
21	A/C Unit 5 Ton	2013	4,772						21
22	Wall Lighting Units	2013	2,546						22
23	Dining Room Cabinets and Countertops	2013	18,929						23
24	Rooftop A/C & Fan Coil	2013	13,477						24
25									25
26	Replace (6) PTAC Units	2014	3,738						26
27	Replace (4) Windows	2014	8,975						27
28	Carpet Installation - T (Sheltered Care) Wing	2014	18,794						28
29	Pole Building Purchase and Installation	2014	13,231						29
30	Remodeling Project Design & Planning	2014	18,360						30
31	New Water Softener	2014	7,683						31
32	New Mixing Valve	2014	3,282						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,303,795	$ 178,208		$ 178,208	$	$	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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,303,795	$ 178,208		$ 178,208	$	$	1
2									2
3	Completed Installation of Pole Building	2015	31,347						3
4									4
5	Install Fencing and Gates - Building Perimeter	2016	9,998						5
6	Remodeling of Floors and Rooms in X and Y Wings -	2016	1,126,256						6
7	Remodeling consisted of new flooring, cabinetry and bathroom								7
8	fixtures for resident rooms and new flooring and wall coverings								8
9	for the corridors. Project also included updating of Family Room area with new flooring and painting.								9
10									10
11	Installed new water heater	2017	10,686						11
12	Purchased new exterior sign	2017	8,898						12
13	Installed new radiator	2017	4,008						13
14	Replace entrance pad and sidewalk	2017	9,974						14
15									15
16	Replace window treatments - T Wing	2018	11,023						16
17	Overlay parking lot and main entrance	2018	52,566						17
18	Sealcoat service drive	2018	3,825						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)		$ 4,572,376	$ 178,208		$ 178,208	$	$	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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 1,032,610	$ 61,617	$ 61,617	$		$	71
72	Current Year Purchases	38,008						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,070,618	$ 61,617	$ 61,617	$		$	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	Transport	2018 Dodge Caravan	2018	$ 41,160	$ 3,430	$ 3,430	$		$	76
77	Transport	2012 Chevy Bus	2013	58,885	8,412	8,412				77
78										78
79										79
80	TOTALS			$ 100,045	$ 11,842	$ 11,842	$		$	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)	$ 5,814,039	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 251,667	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 251,667	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)	$	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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

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: *

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 5,265 Description: Office equipment
(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.

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 107,409	$		$ 107,409	1
2	Licensed Speech and Language Development Therapist		hrs			36,307			36,307	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			124,565	2,172		126,737	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				96,825		96,825	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					15,647			15,647	13
14	TOTAL			$		$ 283,928	$ 98,997		$ 382,925	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 # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ 675,361	$	1
2	Cash-Patient Deposits	6,826		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	416,006		3
4	Supply Inventory (priced at FIFO)	41,848		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,178		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)**	$ 1,155,219	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	104,950		13
14	Buildings, at Historical Cost	4,570,443		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,170,663		16
17	Accumulated Depreciation (book methods)	(3,647,216)		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)**	$ 2,198,840	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,354,059	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 156,975	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,826		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	184,356		30
31	Accrued Taxes Payable (excluding real estate taxes)	59,411		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	8,750		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 416,318	$	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)**	$ 416,318	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,936,619	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,352,937	$	48

*(See instructions.)

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,209,032	1
2	Restatements (describe):		2
3	**Audit Adjustment**	(19,321)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,189,711	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(253,092)	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)**	$ (253,092)	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)**	$ 2,936,619	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,164,549	1
2	Discounts and Allowances for all Levels	(885,900)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,278,649	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	914,033	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 914,033	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	18,168	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,250	16
17	Sale of Drugs	156,896	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,265	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 204,579	23
	D. Non-Operating Revenue		
24	Contributions	42,229	24
25	Interest and Other Investment Income***	6,378	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48,607	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)**	$ 4,445,868	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	998,610	31
32	Health Care	1,920,930	32
33	General Administration	1,234,130	33
	B. Capital Expense		
34	Ownership	260,470	34
	C. Ancillary Expense		
35	Special Cost Centers	284,820	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,698,960	40
41	**Income before Income Taxes (line 30 minus line 40)****	(253,092)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (253,092)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

* **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.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,772	1,886	$ 65,055	$ 34.49	1
2	Assistant Director of Nursing	1,865	1,984	58,814	29.64	2
3	Registered Nurses	10,008	10,647	313,908	29.48	3
4	Licensed Practical Nurses	13,161	14,002	344,720	24.62	4
5	CNAs & Orderlies	40,099	42,659	677,359	15.88	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,347	1,433	41,256	28.79	8
9	Activity Director					9
10	Activity Assistants	5,295	5,633	71,056	12.61	10
11	Social Service Workers	1,575	1,675	29,656	17.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,248	22,604	258,348	11.43	15
16	Dishwashers					16
17	Maintenance Workers	4,473	4,758	76,946	16.17	17
18	Housekeepers	7,481	7,959	93,810	11.79	18
19	Laundry	6,046	6,432	74,292	11.55	19
20	Administrator	1,955	2,080	83,598	40.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,633	9,184	185,693	20.22	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)	124,958	132,936	$ 2,374,511 *	$ 17.86	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		9,000		36
37	Medical Records Consultant		1,310		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,532		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		3,482		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,324		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		94,571		52
53	TOTAL (lines 50 - 52)		$ 94,571		53

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christine Banks			$ 83,598
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,598

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Operations Group	Management	$ 148,870
JM Abbott	Auditing	9,026
Legal adj to Zero		1,667
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 159,563

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,581
Unemployment Compensation Insurance	5,097
FICA Taxes	181,650
Employee Health Insurance	214,718
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	28,591
TOTAL (agree to Schedule V, line 22, col.8)	$ 479,637

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,366
Health Care Worker Background Check	
(Indicate # of checks performed)	970
Patient Background Checks	
PR	7,709
Dues & Subscriptions	4,790
License & Fees	2,372
Less: Public Relations Expense	(7,709)
Non-allowable advertising	(2,790)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,708

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,467
	0
Seminar Expense	1,746
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,213

**See instructions.

Facility Name & ID Number Mason City Area Nursing Home # 38268 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. **Health Care Council of Illinois**

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

(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? **7 Yrs**

(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 **x** 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. $ **148,818**
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? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(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. $ **22,829**

(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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Y**
Firm Name: **JM Abbott**

(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. **None Claimed**
Attach invoices and a summary of services for all architect and appraisal fees

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount	
1009			PETTY CASH	675,361						
1010			CASH IN BANK							
1040			CASH IN BANK-PAYROLL							
1100			ACCOUNTS RECEIVABLE	416,006						
1110			MEDICARE RECEIVABLES							
1125			IPA INCOME RECEIVABLE							
1130			MEDICARE COST REPORT							
1135			ACCOUNTS RECEIVABLE-IC							
1140			UNAPPLIED CASH RECEIPTS							
1145			A/R SUSPENSE-REFUNDS							
1190			ACCRUED INTEREST REC							
1200			PREPAID INSURANCE	15,178						
1220			OTHER PREPAID EXPENSES							
1300			FOOD INVENTORY	41,848						
1310			SUPPLIES INVENTORY							
1409			LAND	0						
1450			FURNITURE & EQUIPMENT	1,170,663						
1460			ACCUM DEPR-FURN & EQUIP	-902,209						
1475			BUILDING & IMPROVEMENTS	4,570,443						
1490			ACCUM DEPR-BUILDING	-2,745,007						
1530			RESIDENT FUNDS	6,826						
1550			LOAN FEES	0						
1560			REAL ESTATE TAX ESCROW							
1575			REIMBURSABLE PURCHASES							
1850			INTRACOMPANY	0						
2010			ACCOUNTS PAYABLE	-156,975						
2095			BONUSES PAYABLE							
2100			ACCRUED PAYROLL	-61,638						
2110			ACCRUED VACATION PAY	-122,718						
2120			UC TAXES PAYABLE							
2125			FICA TAX PAYABLE	-59,411	-59,411					
2130			FIT PAYABLE							
2140			STATE W/H PAYABLE		0					
2145			EARNED INCOME CREDIT							
2150			UC FED CREDIT REDUCTION							
2230			PAYROLL SAVINGS							
2235			IRA W/HOLDINGS							
2240			UNITED WAY							
2245			GROUP INSURANCE PAYABLE							
2246			GROUP INSURANCE PAYABLE-CAFETERIA							
2260			WAGE GARNISHMENTS							
2280			MISC PAYROLL DEDUCTIONS							
2300			ACCRUED INTEREST PAYABLE	0						
2310			SALES TAX PAYABLE							
2320			IPA PAYMENTS PAYABLE	-8,750						
2350			REAL ESTATE TAX PAYABLE	0						
2385			ACTIVITY FUND	0						
2390			SECURITY DEPOSITS	0						
2391			VOLUNTEER FUND							
2393			HEART FUND/BAZAAR							
2395			DEFERRED INC EMP & MEM							
2400			CURRENT PORTION LT DEBT							
2460			INCOME TAXES PAYABLE							
2512			DUE TO RESIDENTS	-6,826						
2600			MORTGAGE PAYABLE	0						
2650			EQUIPMENT LOAN PAYABLE							
2695			CURRENT PORTION LT DEBT							
2696			DEFERRED INCOME TAXES							
2710			COMMON STOCK							
2720			RETAINED EARNINGS	-3,189,711						
2970			PROFIT/LOSS FOR PERIOD	253,092						
3007.1			PATIENT DAYS-PRIVATE	8,194						
3007.2			PATIENT DAYS-IPA	9,845						
3007.3			PATIENT DAYS-MEDICARE	1,317						
3007.4			PATIENT DAYS-CONVERSION							
3007.5			PATIENT DAYS-LICENSED							
3007.6			PATIENT DAYS-TOTAL							
3010		1	BASIC CHARGE-PRIVATE & VA	-4,145,447		0	0	0	0	
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0	
3020		1	BASIC CHARGE-IPA	0		0	0	0	0	
3030		1	BASIC CHARGE-MEDICARE	0		0	0	0	0	
3035		4	DAY CARE/HOME CARE			0	0	0	0	
3040		1	LIGHT NURSING CARE	0		0	0	0	0	
3050		1	MEDIUM NURSING CARE			0	0	0	0	
3060		1	HEAVY NURSING CARE			0	0	0	0	
3061		1	SKILLED NURSING CARE							
3080		1	NURSING SUPPLIES-PRIVATE	-12,301		0	0	0	0	
3081		1	NURSING SUPPLIES-IPA			0	0	0	0	
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0	
3083		1	NURSING SUPPLIES MED PT B							
3100		17	DRUGS	-156,896		0	0	0	0	
3101		17	DRUGS-OTHER							
3110		6	PT-PRIVATE	-914,033		0	0	0	0	
3111		6	PT-IPA			0	0	0	0	
3112		6	PT-MEDICARE PART A			0	0	0	0	
3113		6	PT-MEDICARE PART B			0	0	0	0	
3130		1	PUBLIC AID ASSESSMENT INC	112,683						
3140		19	LABORATORY INCOME			0	0	0	0	
3150		6	SPEECH/OT-PRIVATE			0	0	0	0	
3151		6	SPEECH/OT-IPA			0	0	0	0	
3152		6	SPEECH/OT-MED PART A			0	0	0	0	
3153		6	SPEECH/OT MED PART B							
3410		2	IPA DISCOUNTS	885,900		0	0	0	0	
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0	
3420		2	MEDICARE DISCOUNTS			0	0	0	0	
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0	
3520		16	RENT INCOME	-1,250		6	0	6	-1,250	
3530		13	BEAUTY SHOP	-18,168		0	0	0	0	
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0	
3570		12	VENDING INCOME/EXPENSE	0		0	0	0	0	
3580		12	MANAGEMENT FEES			0	0	0	0	
3590		1	EQUIPMENT RENTAL	-6,801		0	0	0	0	
3595		21	RESIDENT TRANSPORTATION	-25,684		0	0	0	0	
3600		21	MISC INCOME	-2,581		0	0	0	0	
4110			GENERAL & ADMINIST WAGES	173,391	185,693	21	1	17	0	
4111			ADMINISTRATOR WAGES	83,598	83,598	17	1	0	0	
4115			VACATION & SICK - G&A	12,302		21	1	0	0	
4120	4475		EMPLOYEE BENEFITS	26,066	479,637	22	3	0	0	
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0	
4130			EMPLOYEE SCHOLORSHIP WA	2,525	112,683	21	1	0	0	
4135			EMPLOYEE SCHOLORSHIP CO:	0		23	3	0	0	
4220			DIRECTORS FEES	0	0	18	3	0	0	
4250	4255		OFFICE SUPPLIES	17,099	17,099	21	2	0	0	
4260			TELEPHONE	12,320	12,320	21	3	0	0	
4275			TRAINING & EMPLOYEE DEVL	2,569	2,569	23	3	16	0	**
4280			GENERAL TRAVEL	2,467	4,213	24	3	16	0	
4281			MEAL EXPENSE FOR TRAVEL	0		24	3	19	0	
4285			EDUCATION & SEMINAR	1,746		24	3	19	0	***
4290			HELP WANTED ADVERTISING	5,366	67,284	20	3	0	0	-36,135
4291			PROMOTIONAL ADVERTISING	9,942		20	3	25	-9,942	
4292			PUBLIC RELATIONS	7,709		20	3	25	-7,709	
4300			LICENSES & FEES	38,507		20	3	17	0	
4310			DUES & SUBSCRIPTIONS	4,790		20	3	17	-2,790	
4320			CONTRIBUTIONS	150		27	3	20	0	
4350			PROFESSIONAL FEES	11,867	159,563	19	3	22	-1,667	
4355			MEDICAL DIRECTOR	9,000	9,000	9	3	0	0	
4360			UTILIZATION REVIEW	0		10	3	0	0	
4361			OTHER PHYSICIAN FEES			39	3	0	0	
4362			MEDICAL RECORDS CONSULT	1,310		10	3	0	0	
4363			PHARMACIST FEES	4,532		10	3	0	0	
4364			SOC SERV/ACT CONSULT	3,482	3,482	12	3	0	0	
4370			TV RENTAL	3,199		35	3	5	0	
4380			INCOME TAXES		37,232	27	3	26	0	
4383			BACKGROUND CHECKS	970		20	3	26	0	
4400			PAYROLL TAXES	178,070		22	3	0	0	
4401			PAYROLL TAXES ADMINIST	8,677		22	3	0	0	
4410			GROUP INSURANCE	214,718		22	3	0	0	
4420			LIABILITY INSURANCE	72,239	72,239	26	3	0	0	
4425			INSURANCE-OWNERS			22	3	21	0	
4430			WORKMENS COMP INSURANCE	49,581		22	3	0	0	
4450			CENTRAL OFFICE FEES	147,696		19	3	34	0	**
4460			BAD DEBTS	37,000		27	3	24	-37,000	
4470			LOST ITEMS-RESIDENTS	82		27	3	0		
4490			MISCELLANEOUS	0		27	3	0	0	
4510			REAL ESTATE TAXES	0	0	33	3	0	0	
4600			LEASED EQUIPMENT	2,066	5,265	35	3	16	0	
5110			MAINTENANCE SALARIES	71,848	76,946	6	1	0	0	
5120			MAINTENANCE SICK & VAC	5,098		6	1	0	0	
5130			ELECTRIC	46,346	76,644	5	3	0	0	
5131			NATURAL GAS	10,143		5	3	0	0	
5132			HEATING & DEISEL OIL			5	3	0	0	
5133			WATER & SEWER	20,155		5	3	0	0	
5134			TRASH COLLECTION	7,864	103,070	6	3	0	0	
5140			PROPERTY PLANT REPLACEMI	19,520	61,374	6	2	0	0	
5160			GENERAL REPAIR & MAINT	41,854		6	2	0	0	
5165			MAINTENANCE CONTRACTS	95,206		6	3	0	0	
5210			DIETARY WAGES	244,277	258,348	1	1	0	0	
5220			DIETARY SICK & VAC	14,071		1	1	0	0	
5240			SALES TAX			2	3	13	0	
5248			FOOD PURCHASES	223,338	200,509	2	2	0	0	
5250			SUPPLIES-DISHWASHING	2,906	19,639	1	2	0	0	
5260			DIETARY REPLACEMENT	3,551		1	2	0	0	
5270			KITCHEN SUPPLIES-PAPER	13,182		1	2	0	0	
5295			MEAL CREDIT	-22,829		2	2	0	0	
5310			LAUNDRY WAGES	69,378	74,292	4	1	0	0	
5340			LAUNDRY SICK & VAC	4,914		4	1	0	0	
5370			LAUNDRY REPLACEMENT	3,413	7,386	4	2	0	0	
5380			LAUNDRY REIMBURSEMENT			4	3	0	0	
5390			LAUNDRY SUPPLIES	3,973		4	2	0	0	
5410			HOUSEKEEPING WAGES	84,927	93,810	3	1	0	0	
5440			HOUSEKEEPING SICK & VAC	8,883		3	1	0	0	
5480			HOUSEKEEPING SUPPLIES	26,592	26,592	3	2	0	0	
5490			HOUSEKEEPING SUPPLIES-PPR	0		3	2	0	0	
6010			RN WAGES-MEDICARE		1,501,112	10	1	0	0	
6020			RN WAGES-NON MEDICARE	288,259		10	1	0	0	
6030			DON WAGES	65,055		10	1	0	0	
6035			ADON	58,814		10	1	0	0	
6040			RN SICK & VACATION	25,649		10	1	0	0	
6110			LPN WAGES-MEDICARE	326,051		10	1	0	0	
6120			LPN WAGES-NON MEDICARE	0		10	1	0	0	
6130			LPN WAGES OTHER			10	1	0	0	
6140			LPN SICK & VACATION	18,669		10	1	0	0	
6210			AIDE WAGES-MEDICARE			10	1	0	0	
6220			AIDE WAGES-NON MEDICARE	642,889		10	1	0	0	
6230			WARD CLERKS			10	1	0	0	
6240			AIDE VACATION & SICK	34,470		10	1	0	0	
6245			CONTRACT NURSES-RN	0		10	3	0	0	
6246			CONTRACT NURSES-LPN	0		10	3	0	0	
6247			CONTRACT NURSES-AIDES	94,571		10	3	0	0	
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0	
6260			NURSE AIDE TRAINING REIMB	-2		0	0	0	0	
6270			REHAB WAGES	34,314		10	1	0	0	
6275			REHAB SICK & VAC	6,942		10	1	0	0	
6280			NURSING DEPT EDUCATION			23	3	0	0	
6290			NURSING SUPPLIES	22,132	86,791	10	2	0	0	
6295			NURSING SUPPLIES	55,566		10	2	0	0	
6390			REPLACEMENT-NURSING	9,093		10	2	0	0	
6490			NURSING OTHER	165	100,578	10	3	0	0	
7280			DRUG PURCHASES	96,825	98,997	39	2	0	0	***
7281			DRUG PURCHASES-OTHER	0		39	2			
7380			LABORATORY SERVICES	15,647	15,647	39	3	0	0	
7410			HOME HEALTH SALARY			39	1	0	0	
7440			HOME HEALTH SICK & VAC			39	1	0	0	
7450			HOME HEALTH EXPENSES			39	3	0	0	
7510			ACTIVITES WAGES	66,824	71,056	11	1	0	0	
7540			ACTIVITIES SICK & VAC	4,232		11	1	0	0	
7590			ACTIVITIES SUPPLIES	4,611	4,611	11	2	0	0	
7595			ACTIVITIES FEES	0	0	11	3	0	0	
7610			PT WAGES			39	1	0	0	
7611			PT SICK & VACATION			39	1	0	0	
7620			PT FEES	124,565	268,281	39	3	0	0	***
7660			PT SUPPLIES	2,172		39	2	0	0	
7710			SOCIAL SERVICE WAGES	25,604	29,656	12	1	0	0	
7720			SOCIAL SERVICE SICK & VAC	4,052		12	1	0	0	
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	
7740			OT FEE	107,409		39	3	0	0	***
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0	
7770			SPEECH THERAPY FEE	36,307		39	3	0	0	***
7800			BEAUTICIAN WAGES		0	40	1	0	0	
7810			BEAUTICIAN SICK & VAC			40	1	0	0	
7820			BEAUTICIAN FEES	16,539	16,539	40	3	0	0	
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910			VOLUNTEER COORDINATOR			21	1	0	0	
7940			VOL COORD SICK & VAC			21	1	0	0	
7960			VOL COORD SUPPLIES	0		21	2	0	0	
8100			RENT	0	0	34	3	0	0	
8120			INTEREST EXPENSE	2,416	3,538	32	3	14	-3,538	
8130			DEPRECIATION	251,667	251,667	30	3	9	0	
8150			LOAN FEE AMORTIZATION	1,122		32	3	0	0	0
9510			INTEREST INCOME	-6,376		32	0	10	0	
9520			MISC NON-OPERATING INCOME	-42,229		0	0	0	0	
9700			INCOME TAXES	0		0	0	0	0	
				4,537,670	4,698,960					
					161,290					
GRAND TOTALS				253,092					-63,896	
				(NET INCOME)						
				0						

FACILITY NAME:
FACILITY ID: 0

FACILITY UNITS: 162

BALANCE SHEET TOTAL -103,828

1,009	1,009	CASH	675,361
1,100	1,100	ACCTS RECEI	556,453
1,101	1,101	ALLOW. FOR U	(140,447)
1,110	1,110	ACCTS RECEIV-M/C	
1,125	1,125	ACCTS RECEIV-IPA	
1,135	1,135	ACCTS RECEIV-IC	
1,140	1,140	UNAPPLIED CASH RECEIPTS	
1,145	1,145	A/R SUSPENSE-REFUNDS	
1,200	1,200	PREPAID INSU	15,178
1,220	1,220	OTHER PREPAID EXPENSES	
1,300	1,300	DIETARY INVE	0
1,310	1,310	SUPPLIES INV	41,848
1,320	1,320	LINEN INVENTORY	
1,409	1,409	LAND	104,950
1,450	1,450	FURNITURE &	1,170,663
1,460			(902,209)
1,475	1,475	BUILDINGS	4,570,443
1,490	1,490	ACCUM DEPR	(2,745,007)
1,530	1,530	RESIDENT FU	6,826
1,550	1,550	LOAN FEES	0
1,551	1,551	LOAN FEES ADDED	
1,850	1,850	INTERCOMPA	0
2,010	2,010	ACCOUNTS PA	(156,975)
2,100	2,095	BONUSES PAYABLE	
2,100	2,100	ACCRUED PA	(61,638)
2,100	2,100	PR CLEARING-BENEFITS	
2,100	2,100	PR CLEARING-LABOR	
2,110	2,110	ACCRUED PTO	(122,718)
2,120	2,120	U.C. TAXES PA	0
2,125	2,125	FICA TAXES P	(59,411)
2,130	2,130	FEDERAL W/H TAX PAYABLE	
2,140	2,140	STATE W/H TAX PAYABLE	
2,152	2,152	WORKERS COMP ACCRUAL	
2,225	2,225	EMPLOYEEE INSURANCE REFUND	
2,230	2,230	PAYROLL SAVINGS	
2,235	2,240	UNITED FUND	
2,240	2,246	GROUP INSURANCE - CAFETERIA	
2,246	2,250	401K W/H	
2,250			
2,260	2,260	WAGE GARNIS	
2,300	2,300	ACCRUED INT	0
2,320	2,320	IPA PAYMENT	(8,750)
2,350	2,350	REAL ESTATE	0
2,385			0
2,400	2,400	CURRENT PORTION OF LT DEBT	
2,512	2,512	DUE TO RESID	(6,826)
2,600	2,600	LOC	0
2,600			
2,625	2,625	LASALLE CONSTR. LOAN #2	
2,625			
2,695	2,695	CURRENT PORTION OF LT DEBT	
2,720	2,720	RETAINED EA	(3,189,711)
		net income	253,092
		balance	1,122
3,007	3,007	PATIENT DAYS-PI	8,194
3,007	3,007	PATIENT DAYS-IP	9,845
3,007	3,007	PATIENT DAYS-M	1,317
3,007	3,007	PATIENT DAYS-SI	5,248
3,007			
3,007			
3,007			
3,010	3,010	BASIC CHARGE-P	(4,145,447)
3,020	3,020	BASIC CHARGE-II	0
3,030	3,030	BASIC CHARGE-M	0
3,040		ASSESSMENT	112,683
3,050			0
3,060			0
3,061			0
3,080	3,080	NURSING SUPPL-	(12,301)
3,081	3,081	NURSING SUPPLI	0
3,082	3,082	NURSING SUPPLI	0
3,083	3,083	NURSING SUPPLI	0
3,100	3,100	DRUGS-MEDICAR	(156,896)
3,101			0
3,110	3,110	PHYSICAL THERA	(914,033)
3,111			0
3,112	3,112	PHYSICAL THERA	0
3,113	3,113	PHYSICAL THERA	0
3,140	3,140	LABORATORY INCOME	
3,150			0
3,151			
3,152	3,152	ST/OT THERAPY-I	0
3,153	3,153	ST/OT THERAPY-I	0
3,160	3,185	REHAB/ISOLATION/OTHER CHG	
3,410	3,410	IPA/OTHER DISC	0
3,411	3,411	MEDICARE PT B-D	0
3,420	3,420	MEDICARE DISC	879,796
3,500			
3,520	3,520	RENT INCOME	(1,250)
3,530	3,530	BEAUTY SHOP	(18,168)
3,560			0
3,570	3,570	VENDING INCOME	0
3,590	3,590	EQUIPMENT REN	(6,801)
3,595	3,595	RESIDENT TRANS	(25,684)
3,600	3,600	MISC INCOME	(2,581)
4,110	4,110	G&A WAGES	173,391
4,111	4,111	ADMINISTRATOR	83,598
4,115	4,115	G&A PTO & RESE	12,302
4,120	4,120	EMPLOYEE BENE	26,088
4,121			0
4,130	4,130	EMPLOYEE SCHO	2,525
4,135	4,135	EMPLOYEE SCHO	0
4,250	4,250	OFFICE SUPPLIES	7,814
4,255	4,255	POSTAGE	2,203
4,260	4,260	TELEPHONE	12,320
4,275	4,275	TRAINING & EMPL	2,569
4,276			325
4,280	4,280	GENERAL TRAVE	2,467
4,281	4,281	MEAL EXPENSE F	0
4,285	4,285	EDUCATION/SEMI	1,710
4,289	4,289	MEETINGS EXPE	36
4,290	4,290	HELP WANTED AD	5,366
4,291	4,291	PROMOTIONAL A	9,942
4,292	4,292	PUBLIC RELATIO	7,709
4,300	4,300	LICENSE & FEES	38,507
4,310	4,310	DUES & SUBSCRI	4,790
4,320	4,320	CONTRIBUTIONS	150
4,350	4,350	PROFESSIONAL F	11,867
4,355	4,355	MEDICAL DIRECT	9,000
4,362			1,310
4,363			4,532
4,364	4,364	SOCIAL SERV/AC	3,482
4,370	4,370	TV RENTAL	3,199
4,383	4,383	BACKGROUND CH	970
4,390	4,390	OTHER TAXES	0
4,400	4,400	PAYROLL TAXES	178,070
4,401	4,401	PAYROLL TAXES	8,677
4,410	4,410	GROUP INSURAN	214,718
4,420	4,420	LIABILITY INSURA	72,239
4,430	4,430	WORKMAN'S COM	47,935
4,435	4,435	W/C-FIRST AID CL	228
4,436	4,436	DRUG TESTING M	1,093
4,450	4,450	MANAGEMENT FE	147,696
4,460	4,460	BAD DEBTS	37,000
4,461	4,461	BAD DEBTS	6,104
4,470	4,470	LOST ITEMS-RESI	82
4,475	4,475	UNIFORM EXP/PE	(22)
4,486	4,486	SERVICE CONTRA	44,805
4,490	4,490	MISC EXPENSE	210
4,496	4,496	MISC. M.I.S. EXPE	7,082
4,510	4,510	REAL ESTATE TA	0
4,600	4,600	LEASED EQUIPME	2,066
5,110	5,110	MAINTENANCE W	71,848
5,120	5,120	MAINTENANCE PT	5,098
5,130	5,130	ELECTRIC	46,346
5,131	5,131	NATURAL GAS	10,143
5,133	5,133	WATER & SEWER	20,155
5,134	5,134	TRASH COLLECTI	7,864
5,140	5,140	PROP/PLANT REP	19,520
5,160	5,160	GENERAL REPAIR	41,854
5,165	5,165	MAINTENANCE CO	50,401
5,210	5,210	DIETARY WAGES	244,277
5,220	5,220	DIETARY PTO & R	14,071
5,248	5,248	FOOD PURCHASE	223,128
5,250	5,250	SUPPLIES DISHW	2,906
5,260	5,260	REPLACEMENT-D	3,551
5,270	5,270	KITCHEN SUPPLIE	13,182
5,295	5,295	MEAL INCOME	(22,829)
5,310	5,310	LAUNDRY WAGES	69,378
5,340	5,340	LAUNDRY PTO & I	4,914
5,370	5,370	REPLACEMENT-L	3,413
5,380			66
5,390	5,390	SUPPLIES	3,907
5,410	5,410	HOUSEKEEPING	84,927
5,440	5,440	HOUSEKEEPING	8,883
5,480	5,480	SUPPLIES-CLEAN	26,592
5,490	5,490	SUPPLIES-HOUSE	0
6,020	6,020	RN WAGES	288,259
6,030	6,030	DON WAGES	65,055
6,035	6,035	ADON WAGES	58,814
6,040	6,040	RN PTO & RESER	25,649
6,120	6,120	LPN WAGES	326,051
6,140	6,140	LPN PTO & RESEI	18,669
6,220	6,220	AIDES WAGES	642,889
6,240	6,240	AIDES PTO & RES	34,470
6,245		RN CONTR	0
6,246		LPN CONTR	0
6,247		AIDES CONTR	94,571
6,250			0
6,255			0
6,260			(2)
6,270	6,270	REHAB WAGES	34,314
6,275	6,275	REHAB PTO & RE	6,942
6,290	6,290	NURSING SUPPLI	22,132
6,295	6,295	NURSING SUPPLI	55,566
6,390	6,390	REPLACEMENT-N	9,093
6,490	6,490	OTHER	165
7,280	7,280	DRUG PURCHASE	96,825
7,281	7,281	DRUG PURCHASE	0
7,380	7,380	LABORATORY SE	5,940
7,391	7,390	X-RAY SERVICES	9,707
7,393			0
7,510	7,510	ACTIVITIES WAGE	66,824
7,540	7,540	ACTIVITIES PTO &	4,232
7,590	7,590	ACTIVITIES SUPP	4,611
7,620	7,620	PHYSICAL THERA	124,565
7,660	7,660	P.T. SUPPLY - BIL	2,172
7,710	7,710	SOCIAL SERVICE	25,604
7,720	7,720	SOCIAL SERVICE	4,052
7,730	7,730	SOCIAL SERVICE-	0
7,740	7,740	OCCUPATIONAL T	107,409
7,750			
7,770	7,770	SPEECH THERAP	36,307
7,820	7,820	BEAUTICIAN FEE	16,539
7,890			0
7,960			0
8,120	8,120	INTEREST	2,416
8,125			0
8,130	8,130	DEPRECIATION	251,667
8,150			1,122
9,510	9,510	INTEREST INCOM	(6,376)
9,520	9,520	MISC NON-OPERA	(42,229)
9,530	4,220		0
	8,100		0
	9,702		0
	5,230		0
			253,092

Expenses Fixed Assets 0

G/L RECAP CENSUS

Mason City Area Nursing Home
2018 Cost Report
Supplemental Schedules
Reclassification Entries

1. Schedule V - Line 10a to Line 39 - Reclassifications

Line Item		
Purchased Drugs and Medications	$	96,825
Purchased Hospital Services		1,698
Purchased Laboratory Services		5,940
Purchased Radiology Services		8,009
Amount Reclassified to Line 39	$	112,472

2. Schedule V - Line 20 to Line 42 - Reclassification

Line Item		
Provider Participation Fee - $1.50	$	(36,135)
Provider Assesment Fee - $6.07		(112,683)
		(148,818)
Provider Participation Fee		148,818