

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0034256

Facility Name: Mason City Area Nursing Home

Address: 520 N Price Ave Bx32 Mason City 62664
Number City Zip Code

County: Mason

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

HFS ID Number:

Date of Initial License for Current Owners: 1989

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust
IRS Exemption Code 501

☐ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Dave Underwood Telephone Number: 309 823-7135
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 01/01/16 to 12/31/16 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

0034256 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	66	Skilled (SNF)	66	24,156	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,346	5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,502	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,776	7,546	1,224	21,546	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		5,373		5,373	12
13	DD 16 OR LESS					13
14	TOTALS	12,776	12,919	1,224	26,919	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.82%

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 66 and days of care provided 1,224

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: 01/01/16 Ending: 12/31/16

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	247,540	17,192		264,732		264,732		264,732			1
2	Food Purchase		213,965		213,965		213,965		213,965			2
3	Housekeeping	97,158	26,449		123,607		123,607		123,607			3
4	Laundry	64,652	12,056		76,708		76,708		76,708			4
5	Heat and Other Utilities			73,489	73,489		73,489		73,489			5
6	Maintenance	76,434	55,647	82,405	214,486		214,486		214,486			6
7	Other (specify):*											7
8	TOTAL General Services	485,784	325,309	155,894	966,987		966,987		966,987			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,444,015	89,798	20,523	1,554,336		1,554,336		1,554,336			10
10a	Therapy		122,717	33,301	156,018	(155,691)	327		327			10a
11	Activities	70,071	3,785		73,856		73,856		73,856			11
12	Social Services	29,003		3,352	32,355		32,355		32,355			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,543,089	216,300	66,176	1,825,565	(155,691)	1,669,874		1,669,874			16
	C. General Administration											
17	Administrative	78,998			78,998		78,998		78,998			17
18	Directors Fees											18
19	Professional Services			144,562	144,562		144,562	(4,576)	139,986			19
20	Dues, Fees, Subscriptions & Promotions			207,922	207,922	(157,729)	50,193	(33,733)	16,460			20
21	Clerical & General Office Expenses	163,042	19,788	28,832	211,662		211,662		211,662			21
22	Employee Benefits & Payroll Taxes			446,680	446,680		446,680		446,680			22
23	Inservice Training & Education			7,622	7,622		7,622		7,622			23
24	Travel and Seminar			5,581	5,581		5,581	(582)	4,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			70,274	70,274		70,274		70,274			26
27	Other (specify):* Lost Items-Residents			76,576	76,576		76,576	(76,249)	327			27
28	TOTAL General Administration	242,040	19,788	988,049	1,249,877	(157,729)	1,092,148	(115,140)	977,008			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,270,913	561,397	1,210,119	4,042,429	(313,420)	3,729,009	(115,140)	3,613,869			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			232,539	232,539		232,539		232,539			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,551	33,551		33,551	(1,175)	32,376			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,732	4,732		4,732	(1,250)	3,482			35
36	Other (specify):*											36
37	TOTAL Ownership			270,822	270,822		270,822	(2,425)	268,397			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			326,006	326,006	155,691	481,697		481,697			39
40	Barber and Beauty Shops			15,945	15,945		15,945		15,945			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					157,729	157,729		157,729			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			341,951	341,951	313,420	655,371		655,371			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,270,913	561,397	1,822,892	4,655,202		4,655,202	(117,565)	4,537,637			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(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	(1,175)			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	(554)			17
18	Fines and Penalties				18
19	Entertainment	(582)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,576)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(76,249)			24
25	Fund Raising, Advertising and Promotional	(33,179)			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)	\$ (117,565)		\$	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	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (117,565)		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

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		0	33	15
16			24	16
17		(554)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(4,576)	19	22
23				23
24		(76,249)	27	24
25		(33,179)	20	25
26				26
27		(1,250)	35	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	(115,808)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	(4,576)	0	0	0	0	0	0	0	0	0	0	(4,576)	19
20	Fees, Subscriptions & Promotions	(33,733)	0	0	0	0	0	0	0	0	0	0	(33,733)	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	(582)	0	0	0	0	0	0	0	0	0	0	(582)	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):*	(76,249)	0	0	0	0	0	0	0	0	0	0	(76,249)	27
28	TOTAL General Administration	(115,140)	0	0	0	0	0	0	0	0	0	0	(115,140)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(115,140)	0	0	0	0	0	0	0	0	0	0	(115,140)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	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	(1,175)	0	0	0	0	0	0	0	0	0	0	(1,175)	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	(1,250)	0	0	0	0	0	0	0	0	0	0	(1,250)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,425)	0	0	0	0	0	0	0	0	0	0	(2,425)	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)	(117,565)	0	0	0	0	0	0	0	0	0	0	(117,565)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Not for Profit - BOD Listed on Separate Schedule						

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

YES

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	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 # 0034256 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	No compensation paid								\$		1
2	to Board Members										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
---------------------------	------------------------------

0034256

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number**Fax Number**

	1 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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Mason City National Bank		x	Renovation		12-21-15	\$	680,128	12-21-20		\$	33,551	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	680,128			\$	33,551	9
	B. Non-Facility Related*												
10	Interest Income											(1,175)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(1,175)	14
15	TOTALS (line 9+line14)						\$	680,128			\$	32,376	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.)

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 2015 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 2016 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:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015		12	
				FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2015	\$	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.

FACILITY NAME	<u>Mason City Area Nursing Home</u>	COUNTY	<u>Mason</u>
---------------	-------------------------------------	--------	--------------

CONTACT PERSON REGARDING THIS REPORT _____

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. None _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	47,308	B. General Construction Type:	Exterior	Brickl	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	Resident Care			\$ 71,000	1
2					2
3	TOTALS			\$ 71,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	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					166,476		166,476		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:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 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	\$ 166,476		\$ 166,476	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

1	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 Totals from Page 12A, Carried Forward		\$ 2,908,458	\$ 166,476		\$ 166,476	\$	\$	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	\$ 166,476		\$ 166,476	\$	\$	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:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,041,980	\$ 166,476		\$ 166,476	\$	\$	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	\$ 166,476		\$ 166,476	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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 Totals from Page 12C, Carried Forward		\$ 3,303,795	\$ 166,476		\$ 166,476	\$	\$	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	1,118,606						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								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)		\$ 4,463,746	\$ 166,476		\$ 166,476	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,051,868	\$66,063	\$66,063	\$		\$	71
72	Current Year Purchases	30,204						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,082,072	\$66,063	\$66,063	\$		\$	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	5,616,818
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	232,539
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	232,539
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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: *

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: \$ 4,732 Description: Copier & TV's
(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	None		\$	\$	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.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☐ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 146,934	\$		\$ 146,934	1
2	Licensed Speech and Language Development Therapist		hrs			38,715			38,715	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			140,357	327		140,684	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				122,390		122,390	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Lab & Radiology					33,301			33,301	13
14	TOTAL			\$		\$ 359,307	\$ 122,717		\$ 482,024	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 661,583	\$	1
2	Cash-Patient Deposits	13,974		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	828,447		3
4	Supply Inventory (priced at)	40,849		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,660		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)	\$ 1,567,513	\$	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	4,480,149		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,082,072		16
17	Accumulated Depreciation (book methods)	(3,147,941)		17
18	Deferred Charges	1,683		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)	\$ 2,520,913	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,088,426	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 180,729	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,974		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	172,997		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,783		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,416		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	20,389		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 392,288	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	680,128		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)	\$ 680,128	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,072,416	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,016,010	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,088,426	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,939,947	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,939,947	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	76,063	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)	\$ 76,063	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,016,010	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning: 01/01/16

Ending: 12/31/16

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,312,648	1
2	Discounts and Allowances for all Levels	(894,623)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,418,025	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,077,131	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,077,131	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	17,655	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,250	16
17	Sale of Drugs	186,113	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	20,376	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 225,394	23
	D. Non-Operating Revenue		
24	Contributions	9,540	24
25	Interest and Other Investment Income***	1,175	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,715	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)	\$ 4,731,265	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	966,987	31
32	Health Care	1,825,565	32
33	General Administration	1,249,877	33
	B. Capital Expense		
34	Ownership	270,822	34
	C. Ancillary Expense		
35	Special Cost Centers	341,951	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)*	\$ 4,655,202	40
41	Income before Income Taxes (line 30 minus line 40)**	76,063	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 76,063	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? Yes 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.

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	1,879	1,978	\$ 65,067	\$ 32.90	1
2	Assistant Director of Nursing	1,953	2,056	59,193	28.79	2
3	Registered Nurses	8,852	9,318	252,663	27.12	3
4	Licensed Practical Nurses	15,522	16,340	374,277	22.91	4
5	CNAs & Orderlies	44,604	46,952	645,710	13.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,571	1,654	47,105	28.48	8
9	Activity Director					9
10	Activity Assistants	5,569	5,862	70,071	11.95	10
11	Social Service Workers	1,856	1,954	29,003	14.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,745	22,889	247,540	10.81	15
16	Dishwashers					16
17	Maintenance Workers	5,121	5,391	76,434	14.18	17
18	Housekeepers	8,806	9,269	97,158	10.48	18
19	Laundry	5,835	6,142	64,652	10.53	19
20	Administrator	1,984	2,088	78,998	37.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,395	7,784	163,042	20.95	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)	132,692	139,677	\$ 2,270,913 *	\$ 16.26	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		9,000		36
37	Medical Records Consultant		1,840		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,801		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		3,352		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,993		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Certified Nurse Assistants/Aides		13,826		52
53	TOTAL (lines 50 - 52)		\$ 13,826		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Christine Banks			\$78,998
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$78,998
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Heritage Operations Group	Management		\$133,999
JM Abbott	Auditing		8,550
ADP	Payroll tax		1,155
Legal adj to Zero			858
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$144,562
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$53,540
Unemployment Compensation Insurance			10,778
FICA Taxes			173,725
Employee Health Insurance			163,220
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Other Benefits			45,417
TOTAL (agree to Schedule V, line 22, col.8)			\$446,680
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			10,204
Health Care Worker Background Check (Indicate # of checks performed)			810
PR			10,209
Dues & Subscriptions			7,489
License & Fees			2,984
Less: Public Relations Expense			(10,209)
Non-allowable advertising			(5,027)
Yellow page advertising (			)
TOTAL (agree to Sch. V, line 20, col. 8)			\$16,460
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
			2,858
			41
Seminar Expense			2,682
			(582)
Entertainment Expense (			)
TOTAL (agree to Sch. V, line 24, col. 8)			\$4,999

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>Mason City Area Nursing Home</u>	STATE OF ILLINOIS # <u>0034256</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
--	--	---	--------------------------------

Page 22

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?
If YES, give association name and amount. HCCI Yes

(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?
What was the average life used for new equipment added during this period? Yes 7 Years

(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. \$ 157,729
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 benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 25,420

(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? Yes
 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

Mason City Are Nursing Home
HFS ID# 371168043001
HFS Cost Report - December 31, 2016
Schedule V - Column 5 Reclassifications

Add (Subtract)

Reclassification of Provider Participation Fees

Provider Participation Fee - \$1.50	Line 20, Col 3	(36,135)
Provider Assesment Fee - \$6.07	Line 20, Col 3	<u>(121,594)</u>
		<u>(157,729)</u>
Provider Participation Fee	Line 42	<u>157,729</u>

Reclassification of Ancillary Services Cost

Cost of Drugs Purchased	Line 10(a), Col 2	(122,390)
Cost of Lab & Radiology Services Purchased	Line 10(a), Col 3	<u>(33,301)</u>
		<u>(155,691)</u>
Ancillary Service Centers	Line 39	<u>155,691</u>

Mason City Are Nursing Home
HFS ID# 371168043001
HFS Cost Report - December 31, 2016
Board of Directors

<u>Member</u>	<u>Home City</u>	<u>State</u>
Reverend Jim Sprinkel - President	Mason City	IL
Robert Griffin - Vice President	Mason City	IL
Karen Duckworth	Mason City	IL
Bonnie Dunker	Mason City	IL
Kraig Kruse	Easton	IL
Suzanne Lowers	Easton	IL
Kate Nunn	Easton	IL
Dan Shepherd	San Jose	IL