

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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:

xx VOLUNTARY, NON-PROFIT
xx Charitable Corp.
Trust
IRS Exemption Code 501c3

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

In the event there are further questions about this report, please contact:
Name: David M Underwood Telephone Number: (309)8237135
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 1/1/2020 to 12/31/2020 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: 1/1/2020 Ending: 12/31/2020

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	<u>66</u>	Skilled (SNF)	<u>66</u>	<u>24,156</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>31</u>	Sheltered Care (SC)	<u>31</u>	<u>11,346</u>	5
6		ICF/DD 16 or Less			6
7	<u>97</u>	TOTALS	<u>97</u>	<u>35,502</u>	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	<u>8,060</u>	<u>8,986</u>	<u>851</u>	<u>17,897</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>2,745</u>		<u>2,745</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>8,060</u>	<u>11,731</u>	<u>851</u>	<u>20,642</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 58.14%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 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 851

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	250,193	18,469	4,814	273,476		273,476		273,476			1
2	Food Purchase		171,684		171,684		171,684		171,684			2
3	Housekeeping	103,843	22,651		126,494		126,494		126,494			3
4	Laundry	78,317	14,488		92,805		92,805		92,805			4
5	Heat and Other Utilities			73,391	73,391		73,391		73,391			5
6	Maintenance	79,014	67,529	110,336	256,879		256,879	(2,500)	254,379			6
7	Other (specify):*											7
8	TOTAL General Services	511,367	294,821	188,541	994,729		994,729	(2,500)	992,229			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,594,714	99,484	40,922	1,735,120	(5,026)	1,730,094		1,730,094			10
10a	Therapy		52,911	7,906	60,817	(55,719)	5,098		5,098			10a
11	Activities	75,805	4,510		80,315		80,315		80,315			11
12	Social Services	31,585		3,190	34,775		34,775		34,775			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,702,104	156,905	61,018	1,920,027	(60,745)	1,859,282		1,859,282			16
	C. General Administration											
17	Administrative	93,436			93,436		93,436		93,436			17
18	Directors Fees											18
19	Professional Services			196,740	196,740		196,740	(3,084)	193,656			19
20	Dues, Fees, Subscriptions & Promotions			171,824	171,824	(151,649)	20,175	(9,366)	10,809			20
21	Clerical & General Office Expenses	184,179	16,141	8,046	208,366		208,366		208,366			21
22	Employee Benefits & Payroll Taxes			587,105	587,105		587,105		587,105			22
23	Inservice Training & Education			36	36		36		36			23
24	Travel and Seminar			972	972		972		972			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,716	79,716		79,716		79,716			26
27	Other (specify):* Lost resident items			4,084	4,084		4,084	(4,076)	8			27
28	TOTAL General Administration	277,615	16,141	1,048,523	1,342,279	(151,649)	1,190,630	(16,526)	1,174,104			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,491,086	467,867	1,298,082	4,257,035	(212,394)	4,044,641	(19,026)	4,025,615			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			253,089	253,089		253,089		253,089			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,899	3,899		3,899		3,899			35
36	Other (specify):*											36
37	TOTAL Ownership			256,988	256,988		256,988		256,988			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			307,278	307,278	55,719	362,997		362,997			39
40	Barber and Beauty Shops		2,927	13	2,940		2,940		2,940			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					151,649	151,649		151,649			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		2,927	307,291	310,218	207,368	517,586		517,586			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,491,086	470,794	1,862,361	4,824,241	(5,026)	4,819,215	(19,026)	4,800,189			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	(2,500)			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				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	(5,407)			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	(3,084)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,076)			24
25	Fund Raising, Advertising and Promotional	(3,959)			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)	\$ (19,026)		\$	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))	\$ (19,026)		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		(3,084)	19	11
12		0	19	12
13		(4,076)	27	13
14		(3,959)	20	14
15		(5,407)	20	15
16		(2,500)	6	16
17		0	24	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,026)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2020

Ending:

12/31/2020**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	(2,500)	0	0	0	0	0	0	0	0	0	0	(2,500)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,500)	0	0	0	0	0	0	0	0	0	0	(2,500)	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	(3,084)	0	0	0	0	0	0	0	0	0	0	(3,084)	19
20	Fees, Subscriptions & Promotions	(9,366)	0	0	0	0	0	0	0	0	0	0	(9,366)	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):*	(4,076)	0	0	0	0	0	0	0	0	0	0	(4,076)	27
28	TOTAL General Administration	(16,526)	0	0	0	0	0	0	0	0	0	0	(16,526)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,026)	0	0	0	0	0	0	0	0	0	0	(19,026)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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)	(19,026)	0	0	0	0	0	0	0	0	0	0	(19,026)	45

Facility Name & ID Number	Mason City Area Nursing Home
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0034256

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 ☒ 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				\$				\$		\$
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: 1/1/2020 Ending: 12/31/2020

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				0	0			\$ 0		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 # 0034256 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	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.)

		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 2019 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 2020 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:	2015		8	
	2016		9	
	2017		10	
	2018		11	
	2019		12	
NA - Not for Profit - Exempt				

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

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 Mason City Area Nursing Home COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0034256

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2019 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 2019.

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.

A. Square Feet: 35,378

B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Facility		1987	\$ 26,000	1
2			1999	45,000	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	1996 Improvements		1996		24,742					15
16	1997 Improvements		1997		18,665					16
17	1998 Improvements		1998		13,176					17
18	1999 Improvements		1999		16,690					18
19	2000 Improvements		2000		26,956					19
20	2001 Improvements		2001		62,191					20
21	2002 Improvements		2002		14,724					21
22	2003 Improvements		2003		36,388					22
23	2004 Improvements		2004		22,637					23
24	2005 Improvements		2005		31,879					24
25	2006 Improvements		2006		6,234					25
26	2007 Improvements		2007		47,345					26
27	2008 Improvements		2008		25,427					27
28	2009 Improvements		2009		90,463					28
29	2010 Improvements		2010		17,750					29
30	2011 Improvements		2011		13,613					30
31	2012 Improvements		2012		2,610					31
32	2013 Improvements		2013		63,316					32
33	2014 Improvements		2014		74,063					33
34										34
35	Book Depreciation					183,159		183,159		35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 <u>Completed Installation of Pole Building</u>	2015	\$ 31,347	\$		\$	\$	\$	37
38								38
39 <u>Install Fencing and Gates - Building Perimeter</u>	2016	9,998						39
40 <u>Remodeling of Floors and Rooms in X and Y Wings -</u>	2016	1,126,256						40
41 <u>Remodeling consisted of new flooring, cabinetry and bathroom</u>								41
42 <u>fixtures for resident rooms and new flooring and wall coverings</u>								42
43 <u>for the corridors. Project also included updating of Family Room area with new flooring and painting.</u>								43
44								44
45 <u>Installed new water heater</u>	2017	10,686						45
46 <u>Purchased new exterior sign</u>	2017	8,898						46
47 <u>Installed new radiator</u>	2017	4,008						47
48 <u>Replace entrance pad and sidewalk</u>	2017	9,974						48
49								49
50 <u>Replace window treatments - T Wing</u>	2018	11,023						50
51 <u>Overlay parking lot and main entrance</u>	2018	52,566						51
52 <u>Sealcoat service drive</u>	2018	3,825						52
53								53
54 <u>Parking lot sealcoating and striping</u>	2019	4,455						54
55 <u>Replace sprinkler heads</u>	2019	2,896						55
56 <u>High chrome Impeller/Pump replacement</u>	2019	4,562						56
57 <u>Install new condensing and fan coil unit - T Wing</u>	2019	7,050						57
58 <u>Replace Annunciator Panel</u>	2019	2,960						58
59								59
60 <u>Replace fire sprinkler piping</u>	2020	178,410						60
61 <u>Replace dry system air compressor</u>	2020	4,247						61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 4,776,956	\$ 183,159		\$ 183,159	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,081,803	\$60,547	\$60,547	\$		\$	71
72	Current Year Purchases	12,335						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,094,138	\$60,547	\$60,547	\$		\$	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	\$5,880	\$5,880	\$		\$	76
77	Transport	2012 Chevy Bus	2013	58,885	3,503	3,503				77
78										78
79										79
80	TOTALS			\$100,045	\$9,383	\$9,383	\$		\$	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)	\$6,042,139	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$253,089	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$253,089	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	#	0034256	Report Period Beginning:	1/1/2020	Ending:	12/31/2020
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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?

16. Rental Amount for movable equipment: \$ 3,899 Description: Office equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. 2021 \$

13. _____ /2022 \$ _____

14. _____ /2023 \$ _____

*** 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)	\$			

- (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.

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	

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	\$		\$ 136,794	\$		\$ 136,794	1
2	Licensed Speech and Language Development Therapist		hrs			32,692			32,692	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			137,792	72		137,864	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				52,839		52,839	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					7,906			7,906	13
14	TOTAL			\$		\$ 315,184	\$ 52,911		\$ 368,095	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,002,264	\$	1
2	Cash-Patient Deposits	16,508		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	50,754		3
4	Supply Inventory (priced at <u>FIFO</u>)	58,593		4
5	Short-Term Investments			5
6	Prepaid Insurance	20,637		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)	\$ 1,148,756	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	109,405		13
14	Buildings, at Historical Cost	4,770,568		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,194,184		16
17	Accumulated Depreciation (book methods)	(4,154,934)		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: <u>CIP</u>)	4,067		22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,923,290	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,072,046	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 163,321	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	16,508		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,245		30
31	Accrued Taxes Payable (excluding real estate taxes)	697		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	<u>Bed Tax</u>	8,988		36
37	<u>Deferred Stimulus</u>	154,568		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 531,327	\$	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)	\$ 531,327	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,540,719	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,072,046	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,800,259	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,800,259	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(259,540)	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)	\$ (259,540)	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)	\$ 2,540,719	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 3,937,751	1
2	Discounts and Allowances for all Levels	(593,970)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,343,781	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	763,449	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 763,449	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	332,091	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,239	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,500	16
17	Sale of Drugs	77,874	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	17,114	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 432,818	23
	D. Non-Operating Revenue		
24	Contributions	16,735	24
25	Interest and Other Investment Income***	8,681	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 25,416	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund	(763)	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (763)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,564,701	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	994,729	31
32	Health Care	1,920,027	32
33	General Administration	1,342,279	33
	B. Capital Expense		
34	Ownership	256,988	34
	C. Ancillary Expense		
35	Special Cost Centers	310,218	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)*	\$ 4,824,241	40
41	Income before Income Taxes (line 30 minus line 40)**	(259,540)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (259,540)	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.

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	1,421	1,480	\$ 60,400	\$ 40.81	1
2	Assistant Director of Nursing	1,887	1,966	62,003	31.54	2
3	Registered Nurses	6,204	6,462	162,024	25.07	3
4	Licensed Practical Nurses	20,085	20,922	513,768	24.56	4
5	CNAs & Orderlies	46,590	48,531	747,079	15.39	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,540	1,604	49,440	30.82	8
9	Activity Director					9
10	Activity Assistants	5,731	5,970	75,805	12.70	10
11	Social Service Workers	1,861	1,939	31,585	16.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,013	22,930	250,193	10.91	15
16	Dishwashers					16
17	Maintenance Workers	4,789	4,989	79,014	15.84	17
18	Housekeepers	8,494	8,848	103,843	11.74	18
19	Laundry	6,123	6,378	78,317	12.28	19
20	Administrator	1,996	2,080	93,436	44.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,705	10,109	184,179	18.22	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)	138,439	144,208	\$ 2,491,086 *	\$ 17.27	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		\$ 4,814	L1 C3	35
36	Medical Director		9,000	L9 C3	36
37	Medical Records Consultant		558	L10 C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,026	L10a C3	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		3,190	L12 C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,588		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 13,187	L3 C10	50
51	Licensed Practical Nurses		2,412	L3 C10	51
52	Certified Nurse Assistants/Aides		19,729	L3 C10	52
53	TOTAL (lines 50 - 52)		\$ 35,328		53

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

** See instructions.

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Mason City Area Nursing Home

0034256

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christine Banks	Administrator		\$ 93,436
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 93,436

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	\$ 182,817
JM Abbott	Auditing	10,839
Legal adj to Zero		3,084
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 196,740

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 78,468
Unemployment Compensation Insurance	6,287
FICA Taxes	190,568
Employee Health Insurance	239,684
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	72,098
TOTAL (agree to Schedule V, line 22, col.8)	\$ 587,105

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	4,465
Health Care Worker Background Check (Indicate # of checks performed)	557
Patient Background Checks	
Less: Public Relations Expense	(2,334)
Non-allowable advertising	(5,407)
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,809

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
	651
	0
Seminar Expense	321
	0
Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)	\$ 972

* Attach copy of IMRF notifications

**See instructions.

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IL478-2471

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. HCCI - \$5,820

(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 xx NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx 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. \$ 151,649
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. \$ 11,816

(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? NA
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 & Co

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.

HHS-2745 (9-4-00)

Mason City Area Nursing Home
2020 Cost Report
Supplemental Schedules
Reclassification Entries

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

<u>Line Item</u>		
Purchased Drugs and Medications	\$	52,839
Purchased Hospital Services		4,827
Purchased Laboratory Services		2,367
Purchased Radiology Services		712
Amount Reclassified to Line 39	\$	<u><u>60,745</u></u>

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

<u>Line Item</u>		
Provider Participation Fee - \$1.50	\$	(36,234)
Provider Assesment Fee - \$6.07		<u>(115,415)</u>
		<u><u>(151,649)</u></u>
Provider Participation Fee		<u><u>151,649</u></u>

3. Schedule V - Line 10 to Line 10a - Reclass Pharmacy Consultant

<u>Line Item</u>		
Pharmacy Consultant	\$	<u><u>5,026</u></u>