FOR BHF USE

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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 (Number) Mason City (City) 62664 (Zip Code)

County: Mason

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

HFS ID Number:

Date of Initial License for Current Owners: 1989

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 C 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Daniel Curry **Telephone Number:** 309-823-7164
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 01/01/2025 to 12/31/2025 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) Daniel Curry
(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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 2/16/25 & 12/24/25

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	66	Skilled (SNF)	97	26,515	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	0	1,426	5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	27,941	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI: Medicaid Primary	5 MMAI: Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
8	SNF	5,541	4,633	3,507	105	5,427	1,969	1,247	22,429	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	5,541	4,633	3,507	105	5,427	1,969	1,247	22,429	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 80.27%

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 [xx]

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

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 [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter certified beds.
number of certified beds 73

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: Fiscal Year:

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

STATE OF ILLINOIS

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	328,951	19,212	7,676	355,839		355,839		355,839			1
2	Food Purchase		186,049		186,049		186,049		186,049			2
3	Housekeeping	133,972	26,533		160,505		160,505		160,505			3
4	Laundry	115,162	27,402		142,564		142,564		142,564			4
5	Heat and Other Utilities			117,776	117,776		117,776		117,776			5
6	Maintenance	102,304	93,378	84,658	280,340		280,340		280,340			6
7	Other (specify):*											7
8	TOTAL General Services	680,389	352,574	210,110	1,243,073		1,243,073		1,243,073			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	2,437,579	119,090	217,162	2,773,831	111,315	2,885,146		2,885,146			10
10a	Therapy		225,616	15,945	241,561	(236,437)	5,124		5,124			10a
11	Activities	105,530	6,249		111,779		111,779		111,779			11
12	Social Services	49,695		4,114	53,809		53,809		53,809			12
13	CNA Training		2,285		2,285		2,285		2,285			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,592,804	353,240	246,221	3,192,265	(125,122)	3,067,143		3,067,143			16
	C. General Administration											
17	Administrative	132,850			132,850		132,850		132,850			17
18	Directors Fees											18
19	Professional Services			366,116	366,116		366,116	(1,119)	364,997			19
20	Dues, Fees, Subscriptions & Promotions			395,793	395,793	(304,130)	91,663	(34,186)	57,477			20
21	Clerical & General Office Expenses	252,927	10,433	149,957	413,317	(116,439)	296,878		296,878			21
22	Employee Benefits & Payroll Taxes			612,596	612,596		612,596		612,596			22
23	Inservice Training & Education			682	682		682		682			23
24	Travel and Seminar			4,178	4,178		4,178		4,178			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			209,220	209,220		209,220		209,220			26
27	Other (specify):*			42,985	42,985		42,985	(42,985)				27
28	TOTAL General Administration	385,777	10,433	1,781,527	2,177,737	(420,569)	1,757,168	(78,290)	1,678,878			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,658,970	716,247	2,237,858	6,613,075	(545,691)	6,067,384	(78,290)	5,989,094			29

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

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

Facility Name & ID Number Mason City Area Nursing Home #0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			220,035	220,035		220,035		220,035			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,449	1,449		1,449	(1,449)				32
33	Real Estate Taxes			613	613		613	(613)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,342	40,342		40,342	(1,250)	39,092			35
36	Other (specify):*											36
37	**TOTAL Ownership**			262,439	262,439		262,439	(3,312)	259,127			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			395,227	395,227	241,561	636,788		636,788			39
40	Barber and Beauty Shops			1,703	1,703		1,703		1,703			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					304,130	304,130		304,130			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			396,930	396,930	545,691	942,621		942,621			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,658,970	716,247	2,897,227	7,272,444		7,272,444	(81,602)	7,190,842			45

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

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	(1,449)			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	(5,742)			17
18	Fines and Penalties	(34,255)			18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,119)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,730)			24
25	Fund Raising, Advertising and Promotional	(28,444)			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 Real estate taxes paid on non resident proj	(613)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (81,602)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (81,602)		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	xx		15,537	10a	42
43	Prescription Drugs	xx		225,616	10a	43
44	Hospital Services	xx		408	10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 241,561		47

Mason City Area Nursing Home
ID# 0034256
Report Period Beginning: 01/01/2025
Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ (5,742)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11		(8,730)	27	11
12		(613)	33	12
13		(34,255)	27	13
14		(28,444)	20	14
15		0	20	15
16		(1,250)	35	16
17		(1,449)	32	17
18		(1,119)	19	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**	(81,602)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(1,119)	0	0	0	0	0	0	0	0	0	0	(1,119)	19
20	Fees, Subscriptions & Promotions	(34,186)	0	0	0	0	0	0	0	0	0	0	(34,186)	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):*	(42,985)	0	0	0	0	0	0	0	0	0	0	(42,985)	27
28	TOTAL General Administration	(78,290)	0	0	0	0	0	0	0	0	0	0	(78,290)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(78,290)	0	0	0	0	0	0	0	0	0	0	(78,290)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mason City Area Nursing Home # 0034256 **Report Period Beginning:** 01/01/2025 **Ending:** 12/31/2025

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(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	(1,449)	0	0	0	0	0	0	0	0	0	0	(1,449)	32
33	Real Estate Taxes	(613)	0	0	0	0	0	0	0	0	0	0	(613)	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**	(3,312)	0	0	0	0	0	0	0	0	0	0	(3,312)	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)**	(81,602)	0	0	0	0	0	0	0	0	0	0	(81,602)	45

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	100	None		None		
(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 [xx] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

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

STATE OF ILLINOIS **Ownership Listing-1**

Mason City Area Nursing Home

ID# **0034256**

Report Period Beginning: **01/01/2025**

Ending: **12/31/2025**

N/A

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1									1
2	**Mason City Area Nursing Home - An Illinois Not For Profit Company**					100.00000			2
3									3
4	**Heritage Operations Group LLC:**								4
5	Craig		Hart Trust	Hudson	IL			28.42000	5
6	Joseph		Warner Trust	Bloomington	IL			4.00000	6
7	Linda		Hagi Trust	Bloomington	IL			2.41000	7
8	Janice		Hart Trust	Streator	IL			2.41000	8
9	Timothy		Jefferson	Champaign	IL			16.10000	9
10	Paul		Jefferson	Bloomington	IL			16.10000	10
11	Robert		Dickson Family Trust	Naples	IL			1.28000	11
12	Cheryl		Lowney	Lincoln	IL			0.77000	12
13	Steven		Wannemacher	Bloomington	IL			1.85000	13
14	Bruce		Hart	Phoenix	IL			7.30700	14
15	Brian		Hart	Lake Forest	IL			7.30700	15
16	Benjamin		Hart Trust	Bloomington	IL			7.30700	16
17	Jerry		Westwood Trust	Naples	IL			1.60000	17
18	Van		Freiderich	Congerville	IL			0.70000	18
19	Todd		Hart Trust	Bloomington	IL			0.69000	19
20	Allan		Hart	Morton	IL			0.69000	20
21	Connie		Hoselton	Lexington	IL			0.34000	21
22	David		Fehrenbacher	Lincoln	IL			0.08000	22
23	David		Wegman	Normal	IL			0.08000	23
24	David		Hoeper	Fishers	IL			0.05000	24
25	David		Underwood	Peoria	IL			0.08000	25
26	Jane		Hart Trust	Hudson	IL			0.43000	26
27									27
28									28
29									29
30									30
31									31
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69									69
70									70
71									71
72									72
73									73
74									74
75									75

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Board Members are not compensated								$		1
2	for their services										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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 [xx]

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

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

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

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	No Outstanding Debt						$	$			$	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.)

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2025 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

Assessed Value from Real Estate Tax Bill:	2024		8
Real Estate Tax Bill for Calendar Year:	2020		9
	2021		10
	2022		11
	2023		12
	2024		13

Not for profit entity operating under exemption from paying real estate taxes

	FOR BHF USE ONLY		
14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mason City Area Nursing Home COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0034256

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2024 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 2024.

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numb Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,378 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [xx] (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? [xx] (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. List the bed capacity for the building if it differs from the licensed total. Same

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? No

J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility		1987	$ 26,000	1
2	Nursing Facility		2001	45,000	2
3	TOTALS			$ 71,000	3

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$ 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	2015 Improvements			2015	31,347						34
35	Book Depreciation					192,116		192,116			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: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	2016 Improvements	2016	$ 1,136,254	$		$	$	$	37
38	2017 Improvements	2017	33,566						38
39	2018 Improvements	2018	67,414						39
40	2019 Improvements	2019	21,923						40
41									41
42	Replace fire sprinkler piping	2020	178,410						42
43	Replace dry system air compressor	2020	4,247						43
44									44
45	Install air unit - kitchen hood	2021	11,480						45
46	Replace fire suppression system	2021	5,134						46
47	Install 85 gallon water heater	2021	16,000						47
48	Partial roof replacement	2021	11,550						48
49									49
50	Install new flooring - Rms. 105-112-101	2022	3,595						50
51	Replace water softener	2022	6,820						51
52	Install expansion tanks for existing water heaters	2022	11,562						52
53	Insstall new 65 gallon water heater	2022	18,378						53
54	Replace evaporator coil - walk-in cooler	2022	4,958						54
55	Sewer pump parts replacement	2022	5,076						55
56	Reshingle portion of main roof	2022	3,146						56
57	Replace kitchen door	2022	8,796						57
58	Converted screened-in porch to "Four Seasons"	2022	42,134						58
59	room - replaced screens with windows ,								59
60	insultated room, installed new flooring								60
61									61
62	Install new water heater	2023	21,838						62
63	Replace (4) PTAC units	2023	3,024						63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,950,447	$ 192,116		$ 192,116	$	$	70

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

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,950,447	$ 192,116		$ 192,116	$	$	1
2	Removed damaged canopy and replaced with new 28'x10'	2024	5,923						2
3	model								3
4	Replaced dry sprinkler head	2024	4,998						4
5	Replaced water mixing valve	2024	4,600						5
6	Replaced (4) resident room PTAC units	2024	30,214						6
7	Converted 16 semi-private and 1 private rooms from	2024	54,696						7
8	sheltered care to skilled care. Conversion consisted of								8
9	replacing beds, tables, chairs, nightstands and dressers as								9
10	well as installing new overbed lighting and a nurse call								10
11	system. Conversion also included plumbing and electrical work								11
12	to insert a clean utility room and soiled utility room into								12
13	the existing space and installation of a video surveillance								13
14	system. Use of these beds for skilled residents was pending approval as of 12-31-24.								14
15									15
16	Acquired (4) PTAC units for resident rooms	2025	3,074						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)		$ 5,053,952	$ 192,116		$ 192,116	$	$	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: 01/01/2025 Ending: 12/31/2025

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	$ 1,270,449	$ 25,469	$ 25,469	$		$	71
72	Current Year Purchases	84,721						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,355,170	$ 25,469	$ 25,469	$		$	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	$ 2,450	$ 2,450	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 41,160	$ 2,450	$ 2,450	$		$	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)	$ 6,521,282	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 220,035	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 220,035	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: 01/01/2025 Ending: 12/31/2025

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	$
13.	/2027	$
14.	/2028	$

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: $ 40,342 Description: Oxygen concentrators, copiers and printers
(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.

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? ☐ 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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		2,285		2,285
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	$	$ 2,285	$	$ 2,285
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,285			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Mason City Area Nursing Home

STATE OF ILLINOIS
0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	$		$ 169,989	$		$ 169,989	1
2	Licensed Speech and Language Development Therapist		hrs			44,973			44,973	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			180,155	110		180,265	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				225,616		225,616	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					15,945			15,945	13
14	TOTAL			$		$ 411,062	$ 225,726		$ 636,788	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.

STATE OF ILLINOIS

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2025 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,229,479	$	1
2	Cash-Patient Deposits	11,029		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	883,871		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,220		6
7	Other Prepaid Expenses	9,769		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,155,368	$	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	5,020,364		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,396,331		16
17	Accumulated Depreciation (book methods)	(5,295,839)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,230,261	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,385,629	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 222,709	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,029		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	300,080		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,263		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Bed Tax	29,434		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 565,515	$	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)**	$ 565,515	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,820,114	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,385,629	$	48

***(See instructions.)**

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,236,611	1
2	Restatements (describe):		2
3	Rounding error	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,236,612	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	583,502	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)**	$ 583,502	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)**	$ 2,820,114	24 *

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

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,781,780	1
2	Discounts and Allowances for all Levels	(1,225,009)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,556,771	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	849,056	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 849,056	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	78,727	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,744	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,250	16
17	Sale of Drugs	369,710	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,150	19
20	Radiology and X-Ray	6,165	20
21	Other Medical Services	74,659	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 540,405	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	40,865	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 40,865	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Extraordinary Item - Recovery of Employee**	868,849	28
28a	**Retention Credits Net of Fees**		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 868,849	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,855,946	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,243,073	31
32	Health Care	3,192,265	32
33	General Administration	2,177,737	33
	B. Capital Expense		
34	Ownership	262,439	34
	C. Ancillary Expense		
35	Special Cost Centers	396,930	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)***	$ 7,272,444	40
41	**Income before Income Taxes (line 30 minus line 40)****	583,502	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 583,502	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 1,319,121.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	1,118,115.99	45
46	MMAI-Medicaid is the Primary Payer	846,248.01	46
47	MMAI-Medicare is the Primary Payer	8,886.00	47
48	Private Pay	1,285,861.93	48
49	Medicare Part A	723,734.00	49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify) **Medicare Cost Report Settlement**	55,453.00	52
53	Other-(specify) **Medicare Bad Debts**	-104,984.00	53
54	Other-(specify) **Private Insurance**	295,375.07	54
55	Other-(specify) **Equipment Rental**	8,960.00	55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,556,771	56

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,995	2,100	$ 96,841	$ 46.11	1
2	Assistant Director of Nursing	2,036	2,143	102,591	47.87	2
3	Registered Nurses	6,499	6,841	338,055	49.42	3
4	Licensed Practical Nurses	17,167	18,071	637,066	35.25	4
5	CNAs & Orderlies	49,805	52,426	1,258,846	24.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	74	74	4,180	56.49	8
9	Activity Director					9
10	Activity Assistants	5,932	6,244	105,530	16.90	10
11	Social Service Workers	2,205	2,321	49,695	21.41	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,668	18,598	328,951	17.69	15
16	Dishwashers					16
17	Maintenance Workers	5,126	5,396	102,304	18.96	17
18	Housekeepers	7,061	7,433	133,972	18.02	18
19	Laundry	6,339	6,673	115,162	17.26	19
20	Administrator	1,976	2,080	132,850	63.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,606	8,006	252,927	31.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)			0		33
34	TOTAL (lines 1 - 33)	131,489	138,406	$ 3,658,970 *	$ 26.44	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 7,676	Ln 1 Col 3	35
36	Medical Director		9,000	Ln 9 Col 3	36
37	Medical Records Consultant		1,413	Ln 10 Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,124	Ln 10a Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,114	Ln 12 Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 27,327		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	60	$ 4,367	Ln10 Col 3	50
51	Licensed Practical Nurses	305	18,470	Ln10 Col 3	51
52	Certified Nurse Assistants/Aides	3,939	137,851	Ln10 Col 3	52
53	TOTAL (lines 50 - 52)	4,304	$ 160,688		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kirbey Glasnovich (fka Hull)	Administrator		$ 132,850
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 132,850

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	$ 346,247
MCK CPA's	Audit & Tax	16,400
David Underwood	Medicaid Consulting	1,350
David Fehrenbacher	Medicare Consulting	1,000
Legal adj to Zero		1,119
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 366,116

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,868
Unemployment Compensation Insurance	17,000
FICA Taxes	279,911
Employee Health Insurance	233,921
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	25,896
TOTAL (agree to Schedule V, line 22, col.8)	$ 612,596

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	16,098
Health Care Worker Background Check	
(Indicate # of checks performed)	968
Patient Background Checks	
Association Dues (total from pg 22, #4)	11,484
	817
	33,852
Less: Public Relations Expense	( )
PAC and Lobbying payments	(5,742)
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,477

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	3,805
Seminar Expense	373
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,178

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	5,742
	5,742 Total

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	5,742
	5,742 Total

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	11,484
	11,484 Total

(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. $ 5,000 Line 10

(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ 304,130
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) 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

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ None Has any meal income been offset against related costs? Yes Indicate the amount. $ 12,149

(12) 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. $

(13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: MCK CPA's & Advisors

(14) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. None Claimed
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	GL Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 6 pg 3 Col #	Sch 8 pg 3 Line #	pg Adjustment Amount						
1010	PETTY CASH	1,229,479						1,009	CASH	1,229,479			
1010	CASH IN BANK							1,150	1,150 ACCTS RECE	1,599,733			
1040	CASH IN BANK-PAYROLL							1,151	1,151 ALLOW. FOR	(123,862)			
1100	ACCOUNTS RECEIVABLE	883,871						1,110	1,110 ACCTS RECEIV-MIC				
1101	ACCOUNTS RECEIVABLE							1,111	1,111 ACCTS RECEIV-OU				
1120	IPA INCOME RECEIVABLE							1,130	1,130 ACCTS RECEIV-VI				
1130	MEDICARE COST REPORT							1,140	1,140 UNAPPLIED CASH RECEIPTS				
1140	UNAPPLIED CASH RECEIPTS							1,145	1,145 ALLOW. FOR UNAPPLIED-REFUNDS				
1145	SUSPENSE-CASH MISCELLANEOUS							1,200	1,200 PREPAID INSURANCE	21,220			
1160	AR SUSPENSE-REFUNDS							1,220	1,220 OTHER PREP	0			
1165	ACCRUED INTEREST REC							1,300	1,300 DIETARY INVE	0			
1200	PREPAID INSURANCE	21,220						1,310	1,310 SUPPLIES INVENTORY				
1220	OTHER PREPAID EXPENSES	0						1,320	1,320 DRUG INVENTORY				
1300	FOOD INVENTORY							1,400	1,400 LAND	108,400			
1310	SUPPLIES INVENTORY							1,450	1,450 FURNITURE &	1,396,331			
1320	LAND	108,400						1,470	1,470 LEASEHOLD IM	(1,396,331)			
1450	FURNITURE & EQUIPMENT	1,396,331						1,475	1,475 BUILDINGS	1,695,984			
1460	ACCUM DEPR-FURN & EQUIP	-1,234,056						1,490	1,490 ACCUM DEPR	(6,991,783)			
1470	BUILDING & IMPROVEMENTS	5,625,384						1,530	1,530 RESIDENT FU	11,939			
1490	ACCUM DEPR-BUILDING	-4,991,783						1,550	1,550 LOAN FEES	0			
1530	RESIDENT FUNDS	11,939						1,551	1,551 LOAN	0			
1550	LOAN FEES	0						1,650	1,650 INTERCOMPA	0			
1560	REAL ESTATE TAX ESCROW	0						2,010	2,010 ACCOUNTS P	(222,709)			
1600	INTERCOMPANY	0						2,100	2,100 ACCRUED PAY	0			
1650	INTERCOMPANY	0						2,105	2,105 ACCRUED PT	(15,775)			
2010	ACCOUNTS PAYABLE	-222,709						2,150	2,150 PR CLEARING-BENEFITS	0			
2060	BONUSES PAYABLE							2,160	2,160 PR CLEARING-LABOR	0			
2100	ACCRUED PAYROLL	-115,774						2,110	2,110 ACCRUED PT	(124,306)			
2105	ACCRUED PAYROLL PAY	-124,306						2,115	2,115 ACCRUED VA	0			
2120	UC TAXES PAYABLE							2,125	2,125 FICA TAXES P	(2,263)			
2125	FICA TAX PAYABLE	-2,263	-2,263					2,130	2,130 FEDERAL WH TAX PAYABLE				
2130	FED TAX PAYABLE							2,140	2,140 STATE WH TAX PAYABLE				
2135	STATE WH PAYABLE		0					2,160	2,160 WORKERS COMP ACCRUAL				
2140	EARNED INCOME CREDIT							2,220	2,220 EMPLOYEE INSURANCE REFUND				
2150	UC FED CREDIT REDUCTION							2,230	2,230 PAYROLL SAVINGS				
2230	PAYROLL SAVINGS							2,240	2,240 UNITED FUND				
2240	UNITED FUND							2,245	2,245 ACCRUED INT	0			
2245	UNITED WAY							2,246	2,250 401K WH	0			
2250	GROUP INSURANCE PAYABLE							2,250					
2260	GROUP CARDIO-PULMONARY	0						2,260	2,260 WAGE GARNI	0			
2280	MISC DEDUCTIONS							2,265	2,265 ACCRUED INT	0			
2290	MISC PAYROLL DEDUCTIONS							2,300	2,300 IPA PAYMENT	(29,434)			
2300	ACCRUED INTEREST PAYAB	0						2,330	2,330 REAL ESTATE	0			
2310	SALES TAX PAYABLE							2,360	MEDICARE P	0			
2320	REAL ESTATE TAX ACCR	-29,434						2,400	2,400 CURRENT PORTION OF LT DEBT				
2330	REAL ESTATE TAX PAYABLE	0						2,512	2,512 DUE TO RESI	(11,939)			
2380	ACTIVITY FUND	0						2,600	2,600 LOC	0			
2390	SECURITY DEPOSITS							2,605	RPP LOAN	0			
2391	HEARTLAND-ESCROW							2,625	2,625 LASALLE CONSTR. LOAN	0			
2395	DEFERRED INC-ESCROW							2,640					
2396	DEFERRED INC DISP & MEM							2,646	2,646 CURRENT PORTION OF LT DEBT				
2400	CURRENT PORTION LT DEBT							2,730	2,730 RETAINED EA	(2,236,612)			
2500	DEFERRED INCOME								net income	(565,552)			
2512	DUE TO RESIDENTS	-11,939											
2600	RPP LOAN	0											
2650	EQUIPMENT LOAN PAYABLE								balance	0			
2680	CURRENT PORTION LT DEBT												
2690	INTERCOMPANY ADVANCE LOAN	0											
2710	COMMON STOCK												
2730	RETAINED EARNINGS	-2,236,612											
3007	PATIENT DAYS-NON-COD	-565,552									3,007	3.007 PATIENT DAY	0
3007.1	PATIENT DAYS-PRIVATE	0									3,007	3.007 PATIENT DAY	0
3007.2	PATIENT DAYS-IPA	0									3,007	3.007 PATIENT DAY	0
3007.3	PATIENT DAYS-MEDICARE	0									3,007	3.007 PATIENT DAY	0
3007.4	PATIENT DAYS-CONVERSION	0									3,007		0
3007.5	PATIENT DAYS-MEDICAID										3,007		0
3007.6	PATIENT DAYS-TOTAL										3,007		
3010	1 BASIC CHARGE-PRIVATE & V	-6,755,654		0	0	0	0				3,007		
3020	1 BASIC CHARGE-PRIVATE TAX INCOME	0		0	0	0	0				3,010	3.010 BASIC CHARG	(6,755,654)
3030	1 BASIC CHARGE-IPA	0		0	0	0	0				3,020	3.020 BASIC CHARG	0
3050	1 BASIC CHARGE-MEDICARE	0		0	0	0	0				3,030	3.030 BASIC CHARG	0
3055	1 DAY CARE/HOME CARE			0	0	0	0				3,040	ASSESSMENT	0
3040	1 LIGHT NURSING CARE	0		0	0	0	0				3,050		0
3045	1 INTERMEDIATE CARE			0	0	0	0				3,060		0
3060	1 HEAVY NURSING CARE			0	0	0	0				3,061		0
3061	1 SKILLED NURSING CARE			0	0	0	0				3,080	3.080 NURSING SUI	(17,166)
3070	1 NURSING SUPPLIES-PRIVATE	-17,166		0	0	0	0				3,081	3.081 NURSING SUI	0
3081	1 NURSING SUPPLIES-IPA			0	0	0	0				3,082	3.082 NURSING SUI	0
3082	1 NURSING SUPPLIES-MED PT A			0	0	0	0				3,083	3.083 NURSING SUI	0
3083	1 NURSING SUPPLIES-MED PT B										3,100	3.100 DRUGS-MEDI	(369,710)
3100	17 DRUGS	-369,710		0	0	0	0				3,101		0
3110	8 PT-OTHER										3,110	3.110 PHYSICAL TH	(949,056)
3110	8 PT-PRIVATE	-949,056									3,111		0
3111	8 PT-IPA			0	0	0	0				3,112	3.112 PHYSICAL TH	0
3112	8 PT-MEDICARE PART A			0	0	0	0				3,113	3.113 PHYSICAL TH	0
3113	8 PT-MEDICARE PART B			0	0	0	0				3,140	3.140 LABORATORY	(5,100)
3130	1 PUBLIC AID ASSESSMENT INC	0		0	0	0	0				3,150		0
3140	19 LABORATORY INCOME	-6,100		0	0	0	0				3,151		0
3150	9 SPEECH-OT-PRIVATE			0	0	0	0				3,152	3.152 STOTT THERA	0
3151	9 SPEECH-OT-IPA			0	0	0	0				3,160	3.160 RADIOLOGY	(6,160)
3152	9 SPEECH-OT-MED PART A			0	0	0	0				3,165	3.165 RDH/ABSOLUTION	OTHER CHG
3153	20 RADIOLOGY & XRAY	-6,160									3,410	3.410 PACKTHER D	0
3410	2 IPA DISCOUNT	1,220,089		0	0	0	0				3,411	3.411 MEDICARE D	0
3411	2 MEDICARE PART B DISCOUNT			0	0	0	0				3,420	3.420 MISC/MCARE D	(1,150,037)
3412	2 MEDICAID DISCOUNT			0	0	0	0				3,510	3.510 RENT INCOM	(70,000)
3500	3 SNACK-VM REVENUE	-78,727				42	3				3,520	3.520 RENT INCOM	(1,200)
3520	16 RENT INCOME	-1,200		0	0	0	-1,200				3,530	3.530 BEAUTY SHO	(1,744)
3530	11 BEAUTY SHOP	-1,744		0	0	0	0				3,540		0
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0				3,570	3.570 VENDING INC	0
3570	13 VENDING INCOME/EXPENSE	0		0	0	0	0				3,590	3.590 EQUIPMENT I	(6,960)
3580	10 MANAGEMENT FEES	0		0	0	0	0				3,595	3.595 RESIDENT TR	(74,000)
3590	1 EQUIPMENT RENTAL	-6,960		0	0	0	0				3,600	3.600 MISC INCOME	0
3595	21 RESIDENT TRANSPORTATION	-74,000		0	0	0	0				3,610	3.610 INTEREST IN	(39,416)
3600	21 MISC INCOME	0		0	0	0	0				4,111	4.111 ADMINISTRAT	122,600
4110	GENERAL & ADMINIST WAGE	239,410	252,927	21	1	17	0				4,115	4.115 Q&A PTO & RI	13,317
4111	GENERAL & ADMIN-PT	252,927	252,900	21	1	17	0				4,116	4.116 PHARMACIST	20,160
4115	VACATION & SICK - G&A	13,517		21	1	17	0				4,245	4.245 CONTRACT S	0
4120, 4475	EMPLOYEE BENEFITS	25,896	612,596	22	3	0	0				4,130	4.130 EMPLOYEE S	0
4240	CONTRACT SERVICES - ADM	0	0	22	3	0	0				4,135	4.135 EMPLOYEE S	0
4130	EMPLOYEE SCHOLARSHIP R	0	0	21	1	0	0				4,250	4.250 OFFICE SUPP	6,980
4135	EMPLOYEE SCHOLARSHIP O	0	0	21	1	0	0				4,255	4.255 POSTAGE	2,000
4220	DIRECTORS FEES	0	0	18	3	0	0				4,260	4.260 TELEPHONE	4,784
4250, 4255	OFFICE SUPPLIES	10,433	10,433	21	2	0	0				4,275	4.275 TRAINING & E	682
4260	POSTAGE	2,000	2,000	21	2	0	0				4,280		0
4270	TRAINING & EMPLOYEE DEVL	682	682	23	3	16	0	**			4,285	4.285 GENERAL TE	3,805
4280	GENERAL TRAVEL	3,805	4,178	24	3	18	0				4,291	4.291 MEAL EXPEN	0
4281	MEAL EXPENSE FOR TRAVEL	0		24	3	19	0				4,295	4.295 EDUCATION/T	373
4290	EDUCATION & SEMINAR	373		24	3	19	0	**			4,299	4.299 MEETINGS ED	0
4291	PROFESSIONAL ADVERTISING	360,793	360,793	24	3	20	0				4,230	4.230 PROFESSION	16,048
4291	PROMOTIONAL ADVERTISING	28,444		20	3	20	-28,444			304,130	4,291	4.291 PROMOTIONA	28,444
4292	PUBLIC RELATIONS	0		20	3	20	0				4,292	4.292 PUBLIC RELA	0
4295	TRAVEL & MEETINGS	333,048		20	3	20	0				4,293	4.293 TRAVEL & MT	333,048
4310	DUES & SUBSCRIPTIONS	12,301		27	3	17	-5,792				4,310	4.310 DUES & SUBS	12,301
4320	CONTRIBUTIONS	0		27	3	20	0				4,320	4.320 CONTRIBUTIO	0
4350	PROFESSIONAL FEES	21,879	366,116	19	3	22	-1,119				4,350	4.350 PROFESSION	21,879
4355	MEDICAL DIRECTOR	9,000	9,000	9	3	0	0				4,355	4.355 MEDICAL DIR	9,000
4360	OTHER PROFESSIONAL	0		29	3	0	0				4,360	4.360 OTHER PROF	5,000
4361	OTHER PHYSICIANS FEES	0		30	3	0	0				4,362	PHARMACIST	3,124
4362	MEDICAL RECORDS CONSUL	1,413		10	3	0	0				4,364	4.364 SOCIAL SERV	4,114
4363	PSYCHIATRIST	5,000		10	3	0	0				4,365	4.365 PSYCHIATRI	0
4364	SOC SERVICE/T CONSULT	4,114	4,114	12	3	0	0				4,363	4.363 BACS/ROUN	988
4370	TV RENTAL	3,072		35	3	0	0				4,390	4.390 OTHER TAXE	34,202
4380	INCOME TAXES	0	42,965	27	3	26	0				4,400	4.400 PAYROLL TAX	283,121
4383	BACKGROUND CHECKS	988		20	3	26	0				4,401	4.401 PAYROLL TAX	13,790
4400	PAYROLL TAXES	283,121		22	3	0	0				4,410	4.410 WORKERS CO	259,220
4401	PAYROLL TAXES ADMINIST	13,790		22	3	0	0				4,420	4.420 LIABILITY INS	259,220
4410	GROUP INSURANCE	233,921		22	3	0	0				4,430	4.430 WORKMAN'S	53,984
4411	GROUP INSURANCE	259,220	259,220	22	3	0	0				4,431	4.431 WORKMAN'S	0
4420	WORKERS COMPENS	0		22	3	21	0				4,438	4.438 GRUS TESTA	1,884
4430	WORKMENS COMP INSURAN	53,898		22	3	0	0				4,450	4.450 MANAGEMEN	344,240
4450	GENTRAL OFFICE FEES	344,240		19	3	24	0	**			4,460	4.460 BAD DEBTS	8,730
4460	BAD DEBTS	8,730		27	3	24	-8,730				4,461	4.461 BAD DEBTS	104,984
4461	BAD DEBTS-RESIDENTS	0		27	3	24	0				4,462	4.462 BAD DEBTS I	0
4490	MISCELLANEOUS	0		27	3	0	0				4,470	4.470 UNIFORM EXI	(140)
4510	REAL ESTATE TAXES	613	613	33	3	0	-613				4,488	4.488 SERVICE CO	103,970
5100	MAINTENANCE	46,314	46,314	6	1	0	0				4,485	4.485 MISC. N-I.S.	41,203
5110	MAINTENANCE SALARIES	56,014	102,354	6	1	0	0				4,486	4.486 MISC. N-I.S. E	41,203
5120	MAINTENANCE SICK & VAC	5,790		6	1	0	0				4,510	4.510 REAL ESTATE	613
5130	ELECTRIC	77,910	117,776	5	3	0	0				4,600	4.600 LEASED EQU	36,770
5131	NATURAL GAS	19,338		5	3	0	0				5,110	5.110 MAINTENANC	66,314
5132	FUEL OIL/DIESEL OIL			5	3	0	0				5,111	5.111 MAINTENANC	56,014
5133	WATER & SEWER	20,838	84,658	5	3	0	0				5,130	5.130 ELECTRIC	77,910
5134	TRASH COLLECTION	12,876		6	3	0	0				5,131	5.131 NATURAL GA	19,338
5140	PROPERTY INSURANCE	4,643	85,378	6	3	0	0				5,132	5.132 FUEL OIL/D	20,838
5160	GENERAL REPAIR & MAINT	56,732		6	3	0	0				5,134	5.134 TRASH COLLE	12,876
5165	MAINTENANCE CONTRACTS	11,790		6	3	0	0				5,140	5.140 PROPERTY	4,643
5210	DIETARY WAGES	309,517	328,951	7	1	0	0				5,160	5.160 GENERAL RE	56,732
5220	DIETARY SICK & VAC	19,434		7	1	0	0				5,165	5.165 MAINTENANC	11,790
5230	DIETARY OVERTIME	7,676	7,676	7	1	10	0				5,210	5.210 DIETARY WA	309,517
5240	FOOD PURCHASES	156,188	186,699	2	2	0	0				5,220	5.220 DIETARY PTO	19,434
5250	SUPPLIES-DISHWASHING	8,363	19,212	1	2	0	0				5,240	5.240 FOOD PURCH	167,713
5260	SUPPLIES-JANITORIAL	10,849		1	2	0	0				5,250	5.250 SUPPLIES-D	8,363
5270	KITCHEN SUPPLIES-PAPER	11,518		1	2	0	0				5,260	5.260 REPLACEMEN	5,331
5290	MEAL CREDIT	-10,149		2	2	0	0				5,270	5.270 KITCHEN SUP	11,518
5310	LAUNDRY WAGES	109,143	110,162	4	1	0	0				5,290	5.290 MEAL INCOM	(10,149)
5320	LAUNDRY SICK & VAC	6,019		4	1	0	0				5,310	5.310 LAUNDRY WA	109,143
5330	LAUNDRY OVERTIME	16,921	27,402	4	1	0	0				5,320	5.320 LAUNDRY SI	6,019
5360	LAUNDRY REIMBURSEMENT			4	3	0	0				5,370	5.370 REPLACEMEN	16,921
5390	LAUNDRY SUPPLIES	8,481		4	2	0	0				5,230	5.230 DIETARY CO	7,676
5400	HOUSEKEEPING WAGES	133,972	133,972	4	1	0	0				5,300	5.300 LAUNDRY PT	16,921
5420	HOUSEKEEPING SICK & VAC	10,675		3	1	0	0				5,410	5.410 HOUSEKEEPI	110,397
5460	HOUSEKEEPING SUPPLIES	26,533	26,533	3	2	0	0				5,440	5.440 HOUSEKEEPI	10,675
5490	HOUSEKEEPING SUPPLIES-P	0		3	2	0	0				5,480	5.480 SUPPLIES-CL	26,533
6010	RN WAGES-MEDICARE	2,457,379		10	1	0	0				5,490	5.490 SUPPLIES-HC	0
6020	LPN WAGES-MEDICARE	314,167		10	1	0	0				6,010	6.010 RN WAGES	314,167
6030	DON WAGES	56,841	10	1	0	0				6,030	6.030 DON WAGES	56,841	
6035	ADON	102,591	10	1	0	0				6,035	6.035 ADON WAGES	102,591	
6040	RN WAGES-VACATION	227,355	10	1	0	0				6,040	6.040 RN WAGES	227,355	
6110	LPN WAGES-MEDICARE	427,303	10	1	0	0				6,120	6.120 LPN WAGES	427,303	
6120	LPN WAGES-NON MEDICARE	0	10	1	0	0				6,140	6.140 LPN PTO & RE	29,763	
6130	LPN WAGES-OTHER		10	1	0	0				6,220	6.220 AIDES WAGE	1,184,084	
6140	LPN SICK & VACATION	29,763	10	1	0	0				6,240	6.240 AIDES PTO &	84,762	
6150	LPN WAGES-VACATION		10	1	0	0				6,245	AIDES	1,268,846	
6220	AIDE WAGES-NON MEDICARE	1,184,084	10	1	0	0				6,246	LPN CONTR	16,475	
6230	WAGE CLERKS		10	1	0	0				6,247	AIDES CONTR	137,951	
6240	AIDE WAGES-SICK	84,762	10	1	0	0				6,248		0	
6242	CONTRACT NURSES-RN	4,367	10	3	0	0				6,255		2,285	
6246	CONTRACT NURSES-LPN	16,475	10	3	0	0				6,260		0	
6247	CONTRACT NURSES-AIDES	137,951	10	3	0	0				6,270	6.270 REHAB WAGE	4,058	
6250	NURSE AIDE TRAINING WAG	0	0	13	3	0	0				6,275	6.275 REHAB PTO &	122	
6255	NURSE AIDE TRAINING-PAY	2,285	2,285	13	3	0	0				6,280	6.280 REHAB SICK	1,000	
6260	NURSE AIDE TRAINING REIMB	0		13	3	0	0				6,295	6.295 NURSING SUI	68,643	
6270	REHAB WAGES	4,058	10	1	0	0				6,390	6.390 REPLACEMEN	7,366	
6275	REHAB PAY-PTO	122	10	1	0	0				7,010	7.010 DRUGS	369,710	
6280	NURSING SUPPLY-EDUCATION		10	2	0	0				7,085	7.085 DRUG PURCH	0	
6290	NURSING SUPPLIES	43,091	119,090	10	2	0	0				7,281	7.281 DRUG PURCH	0
6295	NURSING SUPPLIES	68,643	10	2	0	0				7,360	7.360 LABORATORY	6,607	
6360	REPLACEMENT-NURSING	7,366	10	2	0	0				7,361	7.360 X-RAY SERVI	6,500	
6380	DRUGS	369,710	217,162	10	2	0	0				7,710		11,939
7085	DRUG PURCHASES	225,816	225,816	39	2	0	0	**			7,715	7.710 SOCIAL SERV	47,140
7281	DRUG PURCHASES-OTHER	0		39	2						7,720	7.720 SOCIAL SERV	2,555
7360	LABORATORY SERVICES	15,945	15,945	39	3	0	0				7,730	7.730 SOCIAL SERV	0
7365	ACTIVITIES SUPPLIES	6,249	6,249	11	2	0	0				7,745	7.745 PHYSICAL TH	66,165
7395	ACTIVITIES FEES	0	0	11	3	0	0				7,740	7.740 OCCUPATION	169,988
7510	PT SUPPLIES			39	1						7,750		0
7515	PT SICK & VACATION			38	1						7,770	7.770 SPEECH THE	44,972
7520	PT FEES	160,153	360,227	38	3	0	0	***			7,835	7.835 BEAUTICIAN	1,703
7525	PT FEES			38	3	0	0	***			7,890		0
7560	PT SUPPLIES	110		39	2						7,960		0
7710	SOCIAL SERVICE WAGES	47,140	49,695	12	1	0	0				8,120	8.120 INTEREST	1,449
7715	SOCIAL SERVICE SICK & VAC	2,555		12	1	0	0						0
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0				8,130	8.130 DEPRECIATIO	220,035
7740	OT FEE	169,989		39	3	0	0	***			8,150		0
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0				9,310	9.310 INTEREST IN	(14,439)
7770	SPEECH THERAPY FEE	44,972		38	3	0	0	***			9,320	9.320 MISC NON-OP	(26,406)
7810	BEAUTICIAN FEES		0	40	3	0	0				9,330		0
7815	BEAUTICIANS SICK & VAC			40	1	0	0				9,150		0
7820	BEAUTICIAN FEES	1,703	1,703	40	3	0	0				9,702		(568,849)
7835	BEAUTICIAN SUPPLIES	0	0	40	2	0	0				9,290		0
7910	VOLUNTEER COORDINATOR			21	1	0	0						(565,552)
7940	VOL COORD SICK & VAC			21	1	0	0						
7960	VOL COORD SUPPLIES	0		21	2	0	0						
8100	RENT	0	0	34	3	14	0						
8110	INTEREST EXPENSE	1,449	1,449	36	3	12	0						
8120	DEPRECIATION	220,035	220,035	32	3	0	0						
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0					
9310	MISC INTEREST IN	-14,439		0	0	10	-1,449						
9320	MISC NON-OPERATING INCO	-568,849		0	0	10	0						
9700	INCOME TAXES	34,202		0	0	0	-34,202						
		6,382,730	7,272,444										
			908,714										
GRAND TOTALS		-565,552					-491,602						
		(NET INCOME)											
		0											

Expenses Fixed Assets 0

Mason City Are Nursing Home
2025 Illinois Public Aid Cost Report
Supplemental Schedules
Reclassification Entries

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

Line Item		
Purchased Drugs and Medications	$	225,616
Purchased Hospital Services		408
Purchased Laboratory Services		8,607
Purchased Radiology Services		6,930
Amount Reclassified to Line 39	$	241,561

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

Line Item	
Provider Participation Fee	304,130

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

Line Item		
Pharmacy Consultant	$	5,124

4. Schedule V - Line 21 to Line 10 - Reclass MDS and Medical Records Wages

Line Item		
MDS Coordinators/Care Planners - Line 21, Col 1	$	(96,527)
Medical Records Specialists - Line 21, Col 1		(19,912)
		(116,439)
Nursing & Medical Records Line 10		116,439