

Facility Name & ID Number Mason City Area Nursing Home

0034256 Report Period Beginning: 01/01/14 Ending: 12/31/14

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	66	Skilled (SNF)	66	24,090	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	31	Sheltered Care (SC)	31	11,315	5
6		ICF/DD 16 or Less			6
7	97	TOTALS	97	35,405	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,942	8,869	1,680	21,491	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		4,844		4,844	12
13	DD 16 OR LESS					13
14	TOTALS	10,942	13,713	1,680	26,335	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.38%

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

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

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

Date started 1989

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

YES Date _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided 1,680

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

Facility Name & ID Number

Mason City Area Nursing Home

0034256

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	236,348	16,207		252,555		252,555	252,555			1
2	Food Purchase		195,817		195,817		195,817	195,817			2
3	Housekeeping	87,255	31,551		118,806		118,806	118,806			3
4	Laundry	73,883	7,237		81,120		81,120	81,120			4
5	Heat and Other Utilities			75,316	75,316		75,316	75,316			5
6	Maintenance	72,349	56,210	72,202	200,761		200,761	200,761			6
7	Other (specify):*										7
8	TOTAL General Services	469,835	307,022	147,518	924,375		924,375	924,375			8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000	9,000			9
10	Nursing and Medical Records	1,386,518	88,979	15,696	1,491,193		1,491,193	1,491,193			10
10a	Therapy		64,590	308,984	373,574	(79,518)	294,056	294,056			10a
11	Activities	64,660	2,881		67,541		67,541	67,541			11
12	Social Services	24,374		3,196	27,570		27,570	27,570			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,475,552	156,450	336,876	1,968,878	(79,518)	1,889,360	1,889,360			16
	C. General Administration										
17	Administrative	75,080			75,080		75,080	75,080			17
18	Directors Fees										18
19	Professional Services			127,913	127,913		127,913	(2,116)	125,797		19
20	Dues, Fees, Subscriptions & Promotions			78,422	78,422	(36,135)	42,287	(28,469)	13,818		20
21	Clerical & General Office Expenses	175,061	25,168	13,697	213,926		213,926	213,926			21
22	Employee Benefits & Payroll Taxes			481,764	481,764		481,764	481,764			22
23	Inservice Training & Education			7,043	7,043		7,043	7,043			23
24	Travel and Seminar			4,523	4,523		4,523	4,523			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			67,396	67,396		67,396	67,396			26
27	Other (specify):*			6,868	6,868		6,868	(6,000)	868		27
28	TOTAL General Administration	250,141	25,168	787,626	1,062,935	(36,135)	1,026,800	(36,585)	990,215		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,195,528	488,640	1,272,020	3,956,188	(115,653)	3,840,535	(36,585)	3,803,950		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:

01/01/14

Ending:

12/31/14

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			146,271	146,271		146,271		146,271			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(10,159)	(10,159)			32
33	Real Estate Taxes			390	390		390	(390)				33
34	Rent-Facility & Grounds							(1,572)	(1,572)			34
35	Rent-Equipment & Vehicles			4,910	4,910		4,910		4,910			35
36	Other (specify):*											36
37	TOTAL Ownership			151,571	151,571		151,571	(12,121)	139,450			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					79,518	79,518		79,518			39
40	Barber and Beauty Shops			9,713	9,713		9,713		9,713			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					36,135	36,135		36,135			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			9,713	9,713	115,653	125,366		125,366			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,195,528	488,640	1,433,304	4,117,472		4,117,472	(48,706)	4,068,766			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: 01/01/14

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,572)			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	(10,159)			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	(390)			15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,116)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)			24
25	Fund Raising, Advertising and Promotional	(28,469)			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)	\$ (48,706)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (48,706)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Mason City Area Nursing Home

ID# 0034256

Report Period Beginning: 01/01/14

Ending: 12/31/14

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(2,116)	19	22
23				23
24		(6,000)	27	24
25		(28,469)	20	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		(36,585)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,116)	0	0	0	0	0	0	0	0	0	0	(2,116)	19
20	Fees, Subscriptions & Promotions	(28,469)	0	0	0	0	0	0	0	0	0	0	(28,469)	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):*	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	27
28	TOTAL General Administration	(36,585)	0	(36,585)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,585)	0	(36,585)	29									

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,159)	0	0	0	0	0	0	0	0	0	0	(10,159)	32
33	Real Estate Taxes	(390)	0	0	0	0	0	0	0	0	0	0	(390)	33
34	Rent-Facility & Grounds	(1,572)	0	0	0	0	0	0	0	0	0	0	(1,572)	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	(12,121)	0	0	0	0	0	0	0	0	0	0	(12,121)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(48,706)	0	0	0	0	0	0	0	0	0	0	(48,706)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

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

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

Facility Name & ID Number

Mason City Area Nursing Home

0034256

Report Period Beginning:

01/01/14

Ending:

12/31/14

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Board Member List is Attached							1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	None								\$	1
2										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: 01/01/14 Ending: 12/31/14

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

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

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

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Interest Income										(10,159)	10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ (10,159)	14				
15	TOTALS (line 9+line14)						\$	\$			\$ (10,159)	15				

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2013 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 2014 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:	2009 _____	8	FOR BHF USE ONLY		
	2010 _____	9	13	FROM R. E. TAX STATEMENT FOR 2013 \$	13
	2011 _____	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2012 _____	11	15	LESS REFUND FROM LINE 6 \$	15
	2013 _____	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2013 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 2013 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 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

Facility Name & ID Number Mason City Area Nursing Home

0034256 Report Period Beginning:

01/01/14 Ending:

12/31/14

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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				\$ <u>437,500</u>	1
2					2
3	TOTALS			\$ <u>437,500</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	97			\$ 2,605,181	\$		\$	\$	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	1990 Improvements		1990	7,990					9
10	1991 Improvements		1991	16,512					10
11	1992 Improvements		1992	22,678					11
12	1993 Improvements		1993						12
13	1994 Improvements		1994	24,788					13
14	1995 Improvements		1995	17,777					14
15									15
16	Water Heater		1997	4,800					16
17	Asphalt Sealer		1997	5,395					17
18	Entrance & Walkway		1997	1,700					18
19	Landscaping		1997	6,770					19
20									20
21	Kitch Central A/C		1996	15,800					21
22	Central A/C Administrative Offices		1996	2,500					22
23	Landscapping		1996	2,710					23
24	Automatic Door Closers		1996	3,732					24
25									25
26	Life Safety Alarm		1998	992					26
27	Sound System Cafeteria		1998	1,442					27
28	Security System		1998	10,742					28
29									29
30	Parking Lot Paving		1999	4,190					30
31	Petroleum tank		1999	12,500					31
32									32
33									33
34	Book Depreciation				100,103		100,103		34
35									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:

01/01/14

Ending:

12/31/14**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Firewalls---ceiling	2000	\$ 10,800	\$		\$	\$	\$	37
38	Facility Remodel--Materials (Carpeting)	2000	16,156						38
39									39
40	Wallpaper	2001	5,552						40
41	Carpet Installation	2001	4,141						41
42	Woodwork Refinishing	2001	418						42
43	Water Heater	2001	6,125						43
44	Facility Remodel--Labor	2001	1,520						44
45	Parking Lot	2001	9,375						45
46	Living room Remodel	2001	415						46
47	Facility Remodel--Materials	2001	23,795						47
48	Ceramic Tile Shower	2001	698						48
49	Hot Water Pump	2001	2,586						49
50	Carpeting and Installation	2001	2,208						50
51	Wander Guard	2001	1,270						51
52	Light Fixtures and Door	2001	2,777						52
53	Flooring	2001	1,311						53
54									54
55	Painting	2002	1,500						55
56	Remodel & Update Nurses Station	2002	13,224						56
57	Decorative consulting	2002							57
58	Living room Remodel	2002							58
59									59
60	Remodel & Update Nurses Station	2003	13,262						60
61	Roof	2003	10,085						61
62	Window Treatments	2003	1,484						62
63	Water Heater	2003	6,355						63
64	Heater/Air Conditioning Unit	2003	1,095						64
65	Rim Device	2003	1,290						65
66	Drywall	2003	2,817						66
67	Flooring								67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,908,458	\$ 100,103		\$ 100,103	\$	\$	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:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,908,458	\$ 100,103		\$ 100,103	\$	\$	1
2									2
3	Wall Coverings	2004	1,392						3
4	Walkin Cooler/Freezer	2004	21,245						4
5									5
6	Condenser	2005	2,106						6
7	Door Alarm	2005	2,059						7
8	Smoke Alarm	2005	3,732						8
9	Parking lot resurface	2005	21,715						9
10	Fire Alarm	2005	2,267						10
11									11
12	Wallpaper--Business office	2006	845						12
13	Therapy room -- Paint	2006	1,595						13
14	PT & Office Remodel -- carpet	2006	3,794						14
15									15
16									16
17	Furnace	2007	3,133						17
18	Surge Protector	2006	9,000						18
19	Install Carpet - Room 104	2007	582						19
20	Dining Room Paint, carpet	2007	22,541						20
21	Water Heater	2007	7,520						21
22	Pipe Valve	2007	4,569						22
23									23
24	Interior Painting and Design	2008	4,852						24
25	Water Heater	2008	8,116						25
26	AC Condensor	2008	2,540						26
27	A/C Units	2008	2,832						27
28	Carpet - T wing (Sheltered Care)	2008	3,522						28
29	Shower	2008	3,565						29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,041,980	\$ 100,103		\$ 100,103	\$	\$	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:

01/01/14

Ending:

12/31/14

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,041,980	\$ 100,103		\$ 100,103	\$	\$	1
2									2
3	Dining Room (Paint, Carpet and fixtures)	2009	18,938						3
4	Sewer Ejection	2009	45,930						4
5	Landscaping	2009	6,135						5
6	Condensor HVAC	2009	5,263						6
7	HVAC units	2009	3,779						7
8	Parking Lot Improvements	2009	6,975						8
9	Shelter Care Wing (paint/wallpaper)	2009	3,443						9
10									10
11	Beauty Shop-- Carpet, Sink, fixtures and Plumbing Labor	2010	9,777						11
12	Parking Lot Improvements	2010	7,973						12
13									13
14	Seal & Stripe Parking Lot	2011	11,040						14
15	A/C condensing unit.	2011	2,573						15
16									16
17	Interior Painting	2012	2,610						17
18									18
19	Lighting Retrofit	2013	5,492						19
20	Water Heaters	2013	18,100						20
21	A/C Unit 5 Ton	2013	4,772						21
22	Wall Lighting Units	2013	2,546						22
23	Dining Room Cabinets and Countertops	2013	18,929						23
24	Rooftop A/C & Fan Coil	2013	13,477						24
25									25
26	Replace (6) PTAC Units	2014	3,738						26
27	Replace (4) Windows	2014	8,975						27
28	Carpet Installation - T (Sheltered Care) Wing	2014	18,794						28
29	Pole Building Purchase and Installation	2014	13,231						29
30	Remodeling Project Design & Planning	2014	18,360						30
31	New Water Softener	2014	7,683						31
32	New Mixing Valve	2014	3,282						32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,303,795	\$ 100,103		\$ 100,103	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 810,834	\$ 46,168	\$ 46,168	\$		\$	71
72	Current Year Purchases	35,977						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 846,811	\$ 46,168	\$ 46,168	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,588,106	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 146,271	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 146,271	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.

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

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. _____ /2015 \$ _____

13. _____ /2016 \$ _____

14. _____ /2017 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 4,910 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Mason City Area Nursing Home # 0034256 Report Period Beginning: 01/01/14 Ending: 12/31/14
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	120,456	\$		\$	120,456	1
2	Licensed Speech and Language Development Therapist		hrs				48,688				48,688	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist		hrs				124,846		66		124,912	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy		# of prescripts						64,524		64,524	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify):											12
13	Other (specify):						14,994				14,994	13
14	TOTAL			\$		\$	308,984	\$	64,590	\$	373,574	14

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

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning: 01/01/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,095,809	\$	1
2	Cash-Patient Deposits	7,597		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	534,238		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,520		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)	\$ 1,685,164	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	104,950		13
14	Buildings, at Historical Cost	3,301,862		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	846,811		16
17	Accumulated Depreciation (book methods)	(2,763,040)		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)	\$ 1,490,583	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,175,747	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 129,736	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	7,597		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,679		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,909		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>	51,850		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 420,771	\$	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)	\$ 420,771	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,754,976	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,175,747	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,482,777	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,482,777	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	272,199	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)	\$ 272,199	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)	\$ 2,754,976	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,061,769	1
2	Discounts and Allowances for all Levels	(822,867)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,238,902	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,001,892	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,001,892	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,389	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,572	16
17	Sale of Drugs	107,376	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,536	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 132,873	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,004	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,004	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,389,671	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	924,375	31
32	Health Care	1,968,878	32
33	General Administration	1,062,935	33
B. Capital Expense			
34	Ownership	151,571	34
C. Ancillary Expense			
35	Special Cost Centers	9,713	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)*	\$ 4,117,472	40
41	Income before Income Taxes (line 30 minus line 40)**	272,199	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 272,199	43

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

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning: 01/01/14

Ending: 12/31/14

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	1,706	1,896	\$ 63,199	\$ 33.33	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	10,793	11,992	312,194	26.03	3
4	Licensed Practical Nurses	13,918	15,464	339,097	21.93	4
5	CNAs & Orderlies	45,110	50,122	639,217	12.75	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,131	1,257	32,811	26.10	8
9	Activity Director					9
10	Activity Assistants	5,271	5,857	64,660	11.04	10
11	Social Service Workers	1,739	1,914	24,374	12.73	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,819	22,021	236,348	10.73	15
16	Dishwashers					16
17	Maintenance Workers	4,719	5,243	72,349	13.80	17
18	Housekeepers	7,167	7,963	87,255	10.96	18
19	Laundry	6,266	6,962	73,883	10.61	19
20	Administrator	1,872	2,080	75,080	36.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,391	8,213	175,061	21.32	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)	126,902	140,984	\$ 2,195,528 *	\$ 15.57	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 0		35
36	Medical Director	9,000		36
37	Medical Records Consultant	1,720		37
38	Nurse Consultant			38
39	Pharmacist Consultant	10,075		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	3,196		45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 23,991		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 0		50
51	Licensed Practical Nurses	85	3,395	51
52	Certified Nurse Assistants/Aides	0		52
53	TOTAL (lines 50 - 52)	85	\$ 3,395	53

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning: 01/01/14

Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
<u>Christine Banks</u>			\$ <u>75,080</u>	<u>Workers' Compensation Insurance</u>	\$ <u>53,407</u>	<u>IDPH License Fee</u>	\$		
				<u>Unemployment Compensation Insurance</u>	<u>16,761</u>	<u>Advertising: Employee Recruitment</u>		<u>6,901</u>	
				<u>FICA Taxes</u>	<u>167,958</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>203,944</u>	(Indicate # of checks performed _____)		<u>610</u>	
				<u>Employee Meals</u>		<u>Patient Background Checks</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>PR</u>		<u>3,412</u>	
				<u>Other</u>	<u>39,694</u>	<u>Dues & Subscriptions</u>		<u>7,135</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>75,080</u>	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>481,764</u>	TOTAL (agree to Sch. V, line 20, col. 8)	
(List each licensed administrator separately.)									
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	<u>Out-of-State Travel</u>	\$	
							<u>In-State Travel</u>		
								<u>2,667</u>	
								<u>0</u>	
							<u>Seminar Expense</u>	<u>1,856</u>	
								<u>0</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
<u>Heritage Operations Group</u>	<u>Mgt</u>		\$ <u>113,500</u>						
<u>JM Abbott</u>	<u>Audit & Tax</u>		<u>9,783</u>						
<u>McKee Environmental</u>	<u>Consulting</u>		<u>1,455</u>						
<u>ADP</u>	<u>Payroll Tax</u>		<u>1,059</u>						
<u>Legal adj to Zero</u>			<u>2,116</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>127,913</u>						
(For legal fee disclosure, see page 39 of instructions)									

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number Mason City Area Nursing Home

0034256

Report Period Beginning:

01/01/14

Ending:

12/31/14

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
- (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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,135
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 32,167
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100%
 - d. Have vehicle usage logs been maintained? Yes
 - e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
 - f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
 - g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: JM Abbott
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details Legal fees removed
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg Line #	Sch 5 pg Col #	Sch 6 pg Line #	Adjustment Amount			
1009	PETTY CASH	1,095,809						1,009	1,009	PETTY CASH 1,095,809
1010	CASH IN BANK							1,100	1,100	ACCTS RECEIVABLE 534,238
1040	CASH IN BANK-PAYROLL							1,101	1,101	ALLOW. FOR UNCOLLECTIBLE
1100	ACCOUNTS RECEIVABLE	534,238						1,110	1,110	ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES							1,125	1,125	ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE							1,135	1,135	ACCTS RECEIV-IC
1130	MEDICARE COST REPORT							1,140	1,140	UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC							1,145	1,145	A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS							1,200	1,200	PREPAID 47,520
1145	A/R SUSPENSE-REFUNDS							1,220	1,220	OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC							1,300	1,300	DIETARY INVENTORY
1200	PREPAID INSURANCE	47,520						1,310	1,310	SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES							1,320	1,320	LINEN INVENTORY
1300	FOOD INVENTORY							1,409	1,409	LAND 104,950
1310	SUPPLIES INVENTORY							1,450	1,450	FURNITURE 846,811
1409	LAND	104,950						1,460		(647,587)
1450	FURNITURE & EQUIPMENT	846,811						1,475	1,475	BUILDING 3,301,862
1460	ACCUM DEPR-FURN & EQUIP	-647,587						1,490	1,490	ACCUM DEPR-BUILDING (2,115,453)
1475	BUILDING & IMPROVEMENTS	3,301,862						1,530	1,530	RESIDENT FUNDS 7,597
1490	ACCUM DEPR-BUILDING	-2,115,453						1,550	1,550	LOAN FEES 0
1530	RESIDENT FUNDS	7,597						1,551	1,551	LOAN FEES ADDED
1550	LOAN FEES	0						1,850	1,850	INTERCOMMUNICATIONS 0
1560	REAL ESTATE TAX ESCROW							2,010	2,010	ACCOUNTS PAYABLE (129,736)
1575	REIMBURSABLE PURCHASES							2,100	2,095	BONUSES PAYABLE
1850	INTRACOMPANY	0						2,100	2,100	ACCRUED PAYROLL (111,075)
2010	ACCOUNTS PAYABLE	-129,736						2,100	2,100	PR CLEARING-BENEFITS
2095	BONUSES PAYABLE							2,100	2,100	PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-111,075						2,110	2,110	ACCRUED PAYROLL (118,604)
2110	ACCRUED VACATION PAY	-118,604						2,120	2,120	U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(1,909)	
2125	FICA TAX PAYABLE	-1,909	-1,909	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE REFU		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETER		
2240	UNITED WAY			2,246	2,250 401K W/H		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE GA		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUEI	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(51,850)	
2300	ACCRUED INTEREST PAYABLE	0		2,350	2,350 REAL EST	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-51,850		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYABLE	0		2,512	2,512 DUE TO F	(7,597)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLE	0	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEB		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINE	(2,482,777)	
2460	INCOME TAXES PAYABLE						
2512	DUE TO RESIDENTS	-7,597					
2600	MORTGAGE PAYABLE	0					
2650	EQUIPMENT LOAN PAYABLE						balance
2695	CURRENT PORTION LT DEBT						<u>0</u>
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-2,482,777					
2970	PROFIT/LOSS FOR PERIOD	-272,199					
3007.1	PATIENT DAYS-PRIVATE	13,713					3,007

3007.2	PATIENT DAYS-IPA	10,942						3,007
3007.3	PATIENT DAYS-MEDICARE	1,680						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE & VA	-4,030,605	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARE	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVATE	-23,306	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-107,376	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-1,001,892	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	822,867	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	-1,572		6	0	6	-1,572		3,530
3530	13 BEAUTY SHOP	-10,389		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	-7,858		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-13,536		0	0	0	0		4,110
3600	21 MISC INCOME	0		0	0	0	0		4,111
4110	GENERAL & ADMINIST WAGES	160,403	175,061	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	75,080	75,080	17	1	0	0		4,120
4115	VACATION & SICK - G&A	14,658		21	1	0	0		4,121
4120	4475 EMPLOYEE BENEFITS	37,956	481,764	22	3	0	0		4,130
4125	EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0		4,135
4130	EMPLOYEE SCHOLORSHIP WAGE	0		21	1	0	0		4,250
4135	EMPLOYEE SCHOLORSHIP COST	1,738		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250	4255 OFFICE SUPPLIES	25,168	25,168	21	2	0	0		4,275
4260	TELEPHONE	13,697	13,697	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVL	7,043	7,043	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	2,667	4,523	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	0		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	1,856		24	3	19	0 ***		4,289
4290	HELP WANTED ADVERTISING	6,901	78,422	20	3	0	0 -36,135		4,290
4291	PROMOTIONAL ADVERTISING	22,147		20	3	25	-22,147		4,291
4292	PUBLIC RELATIONS	3,412		20	3	25	-3,412		4,292
4300	LICENSES & FEES	38,217		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	7,135		20	3	17	-2,910		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	14,413	127,913	19	3	22	-2,116		4,350
4355	MEDICAL DIRECTOR	9,000	9,000	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSULT	1,720		10	3	0	0	4,364
4363	PHARMACIST FEES	10,075		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	3,196	3,196	12	3	0	0	4,383
4370	TV RENTAL	3,697		35	3	5	0	4,390
4380	INCOME TAXES		6,868	27	3	26	0	4,400
4383	BACKGROUND CHECKS	610		20	3	26	0	4,401
4400	PAYROLL TAXES	176,926		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIST	7,793		22	3	0	0	4,420
4410	GROUP INSURANCE	203,944		22	3	0	0	4,430
4420	LIABILITY INSURANCE	67,396	67,396	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSURANCE	53,407		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	113,500		19	3	34	0 **	4,460
4460	BAD DEBTS	6,000		27	3	24	-6,000	4,461
4470	LOST ITEMS-RESIDENTS	868		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	390	390	33	3	0	-390	4,486
4600	LEASED EQUIPMENT	1,213	4,910	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	71,034	72,349	6	1	0	0	4,496
5120	MAINTENANCE SICK & VAC	1,315		6	1	0	0	4,510
5130	ELECTRIC	45,977	75,316	5	3	0	0	4,600
5131	NATURAL GAS	12,287		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	17,052		5	3	0	0	5,130
5134	TRASH COLLECTION	7,914	72,202	6	3	0	0	5,131
5140	PROPERTY PLANT REPLACEMNT	21,908	56,210	6	2	0	0	5,133
5160	GENERAL REPAIR & MAINT	34,302		6	2	0	0	5,134
5165	MAINTENANCE CONTRACTS	64,288		6	3	0	0	5,140
5210	DIETARY WAGES	223,492	236,348	1	1	0	0	5,160
5220	DIETARY SICK & VAC	12,856		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	227,984	195,817	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	2,711	16,207	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	3,503		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	9,993		1	2	0	0	5,260
5295	MEAL CREDIT	-32,167		2	2	0	0	5,270
5310	LAUNDRY WAGES	70,479	73,883	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	3,404		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	2,605	7,237	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	4,632		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	78,886	87,255	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	8,369		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	29,211	31,551	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-PPR	2,340		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		1,386,518	10	1	0	0	5,490
6020	RN WAGES-NON MEDICARE	295,278		10	1	0	0	6,020
6030	DON WAGES	63,199		10	1	0	0	6,030
6035	ADON	0		10	1	0	0	6,035
6040	RN SICK & VACATION	16,916		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	319,990		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICARE	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	19,107		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICARE	595,331		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	43,886		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	3,395		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING WAGES	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING REIMB	0		0	0	0	0	6,295
6270	REHAB WAGES	32,605		10	1	0	0	6,390
6275	REHAB SICK & VAC	206		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	18,157	88,979	10	2	0	0	7,281
6295	NURSING SUPPLIES	64,626		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	6,196		10	2	0	0	7,391
6490	NURSING OTHER	506	15,696	10	3	0	0	7,393
7280	DRUG PURCHASES	64,524	64,590	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	0		39	2			7,540
7380	LABORATORY SERVICES	14,994	308,984	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	60,498	64,660	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	4,162		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	2,881	2,881	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	124,846		39	3	0	0 ***	7,890
7660	PT SUPPLIES	66		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	22,977	24,374	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & VAC	1,397		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSES	0	0	12	2	0	0	8,130
7740	OT FEE	120,456		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	48,688		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	9,713	9,713	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	0	0	32	3	14	-10,159	
8130	DEPRECIATION	146,271	146,271	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-10,159		32	0	10	0	
9520	MISC NON-OPERATING INCOME	0		0	0	0	0	
9700	INCOME TAXES	-5,845		0	0	0	0	

4,101,468 4,117,472
16,004

GRAND TOTALS

-272,199 -48,706
(NET INCOME)

0

FACILITY NAME:

FACILITY ID:

0

FACILITY UNITS:

66

BALANCE SHEET TOTAL

0

	G/L	RECAP CENSUS
PP	13,713	13,713
IPA	10,942	10,942
medic	1,680	1,680
		26,335

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3,007 PATIENT	10,942
3,007 PATIENT	1,680
	0
3,010 BASIC CI	(4,030,605)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0
3,080 NURSING	(23,306)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(107,376)
	0
3,110 PHYSICIAN	(1,001,892)
	0
3,112 PHYSICIAN	0
3,113 PHYSICIAN	0
3,140 LABORATORY INCOME	
	0
3,152 ST/OT TR	0
3,153 ST/OT TR	0
3,185 REHABILITATION/ISOLATION/OTHER CHG	
3,410 IPA/OTHER	0
3,411 MEDICAL	0
3,420 MEDICAL	807,375

3,520 RENT INC	(1,572)
3,530 BEAUTY	(10,389)
	0
3,570 VENDING	0
3,590 EQUIPMI	(7,858)
3,595 RESIDEN	(13,536)
3,600 MISC INC	0
4,110 G&A WA	160,403
4,111 ADMINIS	75,080
4,115 G&A PTC	14,658
4,120 EMPLOY	35,086
4,130 EMPLOY	0
4,135 EMPLOY	1,738
4,250 OFFICE S	11,432
4,255 POSTAGI	3,760
4,260 TELEPHC	13,697
4,275 TRAININ	7,043
	0
4,280 GENERA	2,667
4,281 MEAL EX	0
4,285 EDUCAT	1,795
4,289 MEETING	61
4,290 HELP WA	6,901
4,291 PROMOT	22,147
4,292 PUBLIC I	3,412
4,300 LICENSE	38,217
4,310 DUES & S	7,135
4,320 CONTRIB	0
4,350 PROFESS	14,413
4,355 MEDICAL	9,000
	1,720
	10,075

4,364 SOCIAL S	3,196
4,370 TV RENT	3,697
4,383 BACKGR	610
4,390 OTHER T	0
4,400 PAYROL	176,926
4,401 PAYROL	7,793
4,410 GROUP I	203,944
4,420 LIABILIT	67,396
4,430 WORKM	52,176
4,435 W/C-FIRS	0
4,436 DRUG TE	1,231
4,450 MANAGI	113,500
4,460 BAD DEF	6,000
4,461 BAD DEF	15,492
4,470 LOST ITE	868
4,475 UNIFORM	2,870
4,486 SERVICE	25,292
4,490 MISC EX	713
4,496 MISC. M.	9,976
4,510 REAL ES	390
4,600 LEASED	1,213
5,110 MAINTEI	71,034
5,120 MAINTEI	1,315
5,130 ELECTRI	45,977
5,131 NATURA	12,287
5,133 WATER &	17,052
5,134 TRASH C	7,914
5,140 PROP/PL	21,908
5,160 GENERA	34,302
5,165 MAINTEI	38,996
5,210 DIETARY	223,492
5,220 DIETARY	12,856
5,248 FOOD PU	227,271

5,250 SUPPLIE	2,711
5,260 REPLACI	3,503
5,270 KITCHEN	9,993
5,295 MEAL IN	(32,167)
5,310 LAUNDR	70,479
5,340 LAUNDR	3,404
5,370 REPLACI	2,605
	0
5,390 SUPPLIE	4,632
5,410 HOUSEK	78,886
5,440 HOUSEK	8,369
5,480 SUPPLIE	29,211
5,490 SUPPLIE	2,340
6,020 RN WAG	295,278
6,030 DON WA	63,199
6,035 ADON W	0
6,040 RN PTO &	16,916
6,120 LPN WAG	319,990
6,140 LPN PTO	19,107
6,220 AIDES W	595,331
6,240 AIDES PT	43,886
	3,395
	0
	0
	0
6,270 REHAB V	32,605
6,275 REHAB F	206
6,290 NURSINC	18,157
6,295 NURSINC	64,626
6,390 REPLACI	6,196
6,490 OTHER	506

7,280 DRUG PU	64,524
7,281 DRUG PU	0
7,380 LABORA	6,359
7,390 X-RAY S	8,635
	0
7,510 ACTIVIT	60,498
7,540 ACTIVIT	4,162
7,590 ACTIVIT	2,881
7,620 PHYSICA	124,846
7,660 P.T. SUPE	66
7,710 SOCIAL S	22,977
7,720 SOCIAL S	1,397
7,730 SOCIAL S	0
7,740 OCCUPA	120,456
7,770 SPEECH '	48,688
7,820 BEAUTIC	9,713
	0
	0
8,120 INTERES	0
	0
8,130 DEPRECI	146,271
	0
9,510 INTERES	(10,159)
9,520 MISC NO	(5,845)
4,220	0
8,100	0
9,702	0
5,230	0
	<u>(272,199)</u>

Expenses Fixed Assets

