

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: <u>0050294</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Mason Point</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</u> 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.																									
Address: <u>One Masonic Way</u> <u>Sullivan</u> <u>61951</u> Number City Zip Code																											
County: <u>Moultrie</u>																											
Telephone Number: <u>(217) 728-4394</u> Fax # <u>(217) 728-4221</u>																											
HFS ID Number: _____																											
Date of Initial License for Current Owners: <u>1/1/2009</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>																									
Type of Ownership:																											
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____	Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																									
☐ Charitable Corp.	☐ Individual	☐ State																									
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	☒ Limited Liability Co.	_____																									
	☐ Trust	_____																									
	☐ Other _____	_____																									
In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____																											
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									

Facility Name & ID Number Mason Point# 0050294 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>72</u>	Skilled (SNF)	<u>72</u>	<u>26,280</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,250</u>	3
4		Intermediate/DD			4
5	<u>48</u>	Sheltered Care (SC)	<u>48</u>	<u>17,520</u>	5
6		ICF/DD 16 or Less			6
7	<u>170</u>	TOTALS	<u>170</u>	<u>62,050</u>	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			<u>6,787</u>	<u>6,787</u>	8
9	SNF/PED					9
10	ICF	<u>31,428</u>	<u>14,171</u>	<u>1,247</u>	<u>46,846</u>	10
11	ICF/DD					11
12	SC		<u>2,749</u>		<u>2,749</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>31,428</u>	<u>16,920</u>	<u>8,034</u>	<u>56,382</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.87%

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

None (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?

YesG. 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 1/1/2009

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

YES

☒Date 1/1/2009

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

72

and days of care provided

6,787Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
		1	2	3	4	5	6	7	8		
	A. General Services										
1	Dietary	360,195	25,439		385,634		385,634	(83,831)	301,803		1
2	Food Purchase		284,886		284,886		284,886	(80,984)	203,902		2
3	Housekeeping	140,612	41,325		181,937		181,937	(44,314)	137,623		3
4	Laundry	124,612	45,845		170,457		170,457	(41,578)	128,879		4
5	Heat and Other Utilities			705,007	705,007		705,007	(198,164)	506,843		5
6	Maintenance	197,505	27,419	53,041	277,965		277,965	(62,129)	215,836		6
7	Other (specify):* Home Off. Ben. All.							1,367	1,367		7
8	TOTAL General Services	822,924	424,914	758,048	2,005,886		2,005,886	(509,633)	1,496,253		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,077,677	133,223	12,642	2,223,542		2,223,542	99	2,223,641		10
10a	Therapy	623,101			623,101		623,101	(231,626)	391,475		10a
11	Activities	165,333	729	(1,023)	165,039		165,039	(50,425)	114,614		11
12	Social Services	85,651	366		86,017		86,017		86,017		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	2,951,762	134,318	20,619	3,106,699		3,106,699	(281,952)	2,824,747		16
	C. General Administration										
17	Administrative			270,200	270,200		270,200	(192,216)	77,984		17
18	Directors Fees										18
19	Professional Services			26,397	26,397		26,397	55,444	81,841		19
20	Dues, Fees, Subscriptions & Promotions			8,252	8,252		8,252	202	8,454		20
21	Clerical & General Office Expenses	94,987	19,210	46,316	160,513		160,513	115,172	275,685		21
22	Employee Benefits & Payroll Taxes			482,968	482,968		482,968	(32,736)	450,232		22
23	Inservice Training & Education			867	867		867	194	1,061		23
24	Travel and Seminar							19	19		24
25	Other Admin. Staff Transportation			46,308	46,308		46,308	13,313	59,621		25
26	Insurance-Prop.Liab.Malpractice			66,089	66,089		66,089	2,194	68,283		26
27	Other (specify):* Home Off. Ben. All.							27,409	27,409		27
28	TOTAL General Administration	94,987	19,210	947,397	1,061,594		1,061,594	(11,005)	1,050,589		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,869,673	578,442	1,726,064	6,174,179		6,174,179	(802,590)	5,371,589		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			6,253	6,253		6,253	111,159	117,412			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,339	38,339		38,339	191,512	229,851			32
33	Real Estate Taxes							181,118	181,118			33
34	Rent-Facility & Grounds			400,079	400,079		400,079	(400,079)				34
35	Rent-Equipment & Vehicles			22,471	22,471		22,471	1,445	23,916			35
36	Other (specify):*											36
37	TOTAL Ownership			467,142	467,142		467,142	85,155	552,297			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		134,162		134,162		134,162		134,162			39
40	Barber and Beauty Shops			1,326	1,326		1,326	(1,326)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			433,333	433,333		433,333		433,333			42
43	Other (specify):* Non-allowable Costs	38,229	7,216	563,533	608,978		608,978	(608,978)				43
44	TOTAL Special Cost Centers	38,229	141,378	998,192	1,177,799		1,177,799	(610,304)	567,495			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,907,902	719,820	3,191,398	7,819,120		7,819,120	(1,327,739)	6,491,381			45

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

		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	(11,818)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,908)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,960)	30		9
10	Interest and Other Investment Income	(910)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(775)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(308,661)	43		18
19	Entertainment				19
20	Contributions	(11,750)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(183,891)	43		24
25	Fund Raising, Advertising and Promotional	(20,669)	43		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 See Page 5A	(940,371)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,501,713)		\$	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)	173,974	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 173,974		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,327,739)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Mason Point

	ID#	0050294
Report Period Beginning:		1/1/2012
Ending:		12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,350)	43	1
2	X-Rays-Part A	(5,357)	43	2
3	Offset Privately Paid Electricity	(26,952)	5	3
4	Offset Transportation Revenue	(50,425)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(948)	21	5
6	Offset Chamber of Commerce Dues	(588)	20	6
7	Offset Therapy Revenue	(231,626)	10A	7
8	Resident Flowers	(1,657)	43	8
9	Disallowed Special Events	(723)	43	9
10	Pet Expense	(756)	43	10
11	Offset Independent Living Depreciation	(36,863)	30	11
12	Offset Independent Living Dietary	(94,095)	1	12
13	Offset Independent Living Food	(69,512)	2	13
14	Offset Independent Living Housekeeping	(44,393)	3	14
15	Offset Independent Living Laundry	(41,592)	4	15
16	Offset Independent Living Utilities	(172,022)	5	16
17	Offset Independent Living Maintenance	(67,823)	6	17
18	Disallowed Marketing Salaries	(38,229)	43	18
19	Offset Benefits on Therapy Revenue	(32,736)	33	19
20	Offset Privately Paid Telephone	(1,146)	21	20
21	Disallowed IDES Interest Expense	(16,252)	43	21
22	Offset Barber and Beauty Revenue	(1,326)	31	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	(940,371)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mason Point

0050294

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(94,095)	10,264	0	0	0	0	0	0	0	0	0	(83,831)	1
2	Food Purchase	(81,330)	346	0	0	0	0	0	0	0	0	0	(80,984)	2
3	Housekeeping	(44,393)	79	0	0	0	0	0	0	0	0	0	(44,314)	3
4	Laundry	(41,592)	14	0	0	0	0	0	0	0	0	0	(41,578)	4
5	Heat and Other Utilities	(198,974)	810	0	0	0	0	0	0	0	0	0	(198,164)	5
6	Maintenance	(67,823)	5,694	0	0	0	0	0	0	0	0	0	(62,129)	6
7	Other (specify):*	0	1,367	0	0	0	0	0	0	0	0	0	1,367	7
8	TOTAL General Services	(528,207)	18,574	0	0	0	0	0	0	0	0	0	(509,633)	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	99	0	0	0	0	0	0	0	0	0	99	10
10a	Therapy	(231,626)	0	0	0	0	0	0	0	0	0	0	(231,626)	10a
11	Activities	(50,425)	0	0	0	0	0	0	0	0	0	0	(50,425)	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	(282,051)	99	0	0	0	0	0	0	0	0	0	(281,952)	16
	C. General Administration													
17	Administrative	0	(192,216)	0	0	0	0	0	0	0	0	0	(192,216)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	55,444	0	0	0	0	0	0	0	0	0	55,444	19
20	Fees, Subscriptions & Promotions	(588)	0	790	0	0	0	0	0	0	0	0	202	20
21	Clerical & General Office Expenses	(2,094)	0	116,184	1,082	0	0	0	0	0	0	0	115,172	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	194	0	0	0	0	0	0	0	0	194	23
24	Travel and Seminar	0	0	19	0	0	0	0	0	0	0	0	19	24
25	Other Admin. Staff Transportation	0	0	13,313	0	0	0	0	0	0	0	0	13,313	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,194	0	0	0	0	0	0	0	0	2,194	26
27	Other (specify):*	0	0	27,409	0	0	0	0	0	0	0	0	27,409	27
28	TOTAL General Administration	(2,682)	(136,772)	160,103	1,082	0	0	0	0	0	0	0	21,731	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(812,940)	(118,099)	160,103	1,082	0	0	0	0	0	0	0	(769,854)	29

Summary B

12/31/2012

												SUMMARY
Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)
Depreciation	(44,823)	0	9,862	146,120	0	0	0	0	0	0	0	111,159
Amortization of Pre-Op. & Org.	(1,326)	0	0	0	0	0	0	0	0	0	0	(1,326)
Interest	(910)	0	19,607	172,815	0	0	0	0	0	0	0	191,512
Real Estate Taxes	(32,736)	0	1,452	179,666	0	0	0	0	0	0	0	148,382
Rent-Facility & Grounds	0	0	0	(400,079)	0	0	0	0	0	0	0	(400,079)
Rent-Equipment & Vehicles	0	0	1,445	0	0	0	0	0	0	0	0	1,445
Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL Ownership	(79,795)	0	32,366	98,522	0	0	0	0	0	0	0	51,093
Ancillary Expense												
E. Special Cost Centers												
Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0
Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0
Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0
Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0
Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0
Other (specify):*	(608,978)	0	0	0	0	0	0	0	0	0	0	(608,978)
TOTAL Special Cost Centers	(608,978)	0	0	0	0	0	0	0	0	0	0	(608,978)
GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,501,713)	(118,099)	192,469	99,604	0	0	0	0	0	0	0	(1,327,739)

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.

[illegible]

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.

☒	X	YES	☐	NO
--	----------	------------	--------------------------	-----------

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	<u>Dietary</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 10,264	\$ 10,264	1
2	V	2	<u>Food</u>		<u>Petersen Health Care, Inc.</u>	100.00%	346	346	2
3	V	3	<u>Housekeeping</u>		<u>Petersen Health Care, Inc.</u>	100.00%	79	79	3
4	V	4	<u>Laundry</u>		<u>Petersen Health Care, Inc.</u>	100.00%	14	14	4
5	V	5	<u>Utilities</u>		<u>Petersen Health Care, Inc.</u>	100.00%	810	810	5
6	V	6	<u>Maintenance</u>		<u>Petersen Health Care, Inc.</u>	100.00%	5,694	5,694	6
7	V	7	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,367	1,367	7
8	V	10	<u>Nursing and Medical Records</u>		<u>Petersen Health Care, Inc.</u>	100.00%	99	99	8
9	V	10A	<u>Therapy</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		9
10	V	15	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		10
11	V	17	<u>Administrative</u>	270,200	<u>Petersen Health Care, Inc.</u>	100.00%	77,984	(192,216)	11
12	V	19	<u>Professional Services</u>		<u>Petersen Health Care, Inc.</u>	100.00%	55,444	55,444	12
13	V								13
14	Total			\$ 270,200			\$ 152,101	\$ * (118,099)	14

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

VII. RELATED PARTIES (continued)

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	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 790	\$ 790	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	116,184	116,184	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	194	194	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	19	19	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	13,313	13,313	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	2,194	2,194	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	27,409	27,409	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	9,862	9,862	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	19,607	19,607	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,452	1,452	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	1,445	1,445	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 192,469	\$ * 192,469	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical and General Office	\$	Petersen Health Care VII, LLC	100.00%	\$ 1,082	\$ 1,082	15
16	V	30	Depreciation		Petersen Health Care VII, LLC	100.00%	146,120	146,120	16
17	V	32	Interest		Petersen Health Care VII, LLC	100.00%	172,099	172,099	17
18	V	32	Amortization		Petersen Health Care VII, LLC	100.00%	716	716	18
19	V	33	Real Estate Taxes		Petersen Health Care VII, LLC	100.00%	179,666	179,666	19
20	V	34	Rent-Facility and Grounds	400,079	Petersen Health Care VII, LLC	100.00%	0	(400,079)	20
21	V	43	Fines and Penalties		Petersen Health Care VII, LLC	100.00%	0		21
22	V					100.00%	0		22
23	V					100.00%	0		23
24	V					100.00%	0		24
25	V					100.00%	0		25
26	V					100.00%	0		26
27	V					100.00%	0		27
28	V					100.00%	0		28
29	V					100.00%	0		29
30	V					100.00%	0		30
31	V					100.00%	0		31
32	V					100.00%	0		32
33	V					100.00%	0		33
34	V					100.00%	0		34
35	V					100.00%	0		35
36	V					100.00%	0		36
37	V					100.00%	0		37
38	V					100.00%	0		38
39	Total			\$ 400,079			\$ 499,683	\$ * 99,604	39

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

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				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

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											1
2											2
3											3
4	N/A										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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	First Financial Bank		X	Mortgage	\$21,630.60	11/1/2010	3,042,908	\$ 2,859,280	11/01/2030	0.0590	\$ 172,099	1	
2												2	
3								Interest Income Offset			(910)	3	
4								Home Office Allocation-PHC			19,607	4	
5								Amortization of Loan Costs			966	5	
	Working Capital												
6	First Financial Bank		X	Line of Credit	Varies	3/31/2012	799,022	799,022	3/31/2013	Varies	38,089	6	
7												7	
8												8	
9	TOTAL Facility Related				\$21,630.60		\$ 3,841,930	\$ 3,658,302			\$ 229,851	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,841,930	\$ 3,658,302			\$ 229,851	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NoneLine # N/A

* 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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	103,380	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.)		2011		\$	139,430	2
3. Under or (over) accrual (line 2 minus line 1).				\$	36,050	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	143,616	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.					1,452	
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.				\$	181,118	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007		8
2008		9
2009	101,473	10
2010	100,327	11
2011	139,430	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Mason Point

COUNTY
Moultrie

FACILITY IDPH LICENSE NUMBER
0050294

CONTACT PERSON REGARDING THIS REPORT
Mark Petersen

TELEPHONE
(309)691-8113
FAX #:
(309) 691-8622

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	09-09-05-000-106	Long-Term Nursing Facility	\$ 139,429.82	\$ 139,429.82
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 139,429.82	\$ 139,429.82

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 X 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 237,402 **B. General Construction Type:** Exterior Brick Frame Metal Masonry Number of Stories Bldgs. Vary 1,2, or 3

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).

N/A

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	Facility	1,568,160	2009	\$ 309,300	1
2					2
3	TOTALS	1,568,160		\$ 309,300	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			2009	1950	\$ 2,045,700	\$	25	\$ 81,828	\$ 81,828	\$ 286,398	4
5	24			1955							5
6	72			1983							6
7	50			1986							7
8	48			1981							8
	Improvement Type**										
9	Generator Repair			2009	2,937		7	420	420	1,470	9
10	Automatic Door Opener/Closer			2010	8,185		15	546	546	1,365	10
11	Roof Repairs			2011	9,265		7	2,648	2,648	3,972	11
12	Elevator Repair			2012	4,817		7	344	344	344	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31	Building Booked					81,828			(81,828)		31
32	Building Improvement Booked					2,862			(2,862)		32
33											33
34	2012-Home Office Allocation-Building Improvements				26,369			632	632		34
35	2012-Home Office Allocation-Land Improvements				2,461			157	157		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

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			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,099,734	\$ 84,690		\$ 86,575	\$ 1,885	\$ 293,549	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$212,393	\$30,342	\$21,240	\$ (9,102)	10 yrs.	\$51,080	71
72	Current Year Purchases	10,471	478	524	46	10 yrs.	524	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			9,073	9,073			74
75	TOTALS	\$222,864	\$30,820	\$30,837	\$17		\$51,604	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	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,631,898	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$115,510	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$117,412	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$1,902	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$345,153	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	Duplexes, Apartments, Other Bldg.	\$776,000	\$36,863	\$147,453	86
87					87
88					88
89					89
90					90
91	TOTALS	\$776,000	\$36,863	\$147,453	91

G. Construction-in-Progress

	Description	Cost	
92			92
93	N/A		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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- ☐ YES☐ NO

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

**

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ 23,916 Description: See Attached Schedule 14A
- (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

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. _____/2013 \$ _____
13. _____/2014 \$ _____
14. _____/2015 \$ _____

* 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.

Mason Point
0010249
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	2,588
Dishwasher		930
Laundry Equipment		-
Maintenance Equipment		(21)
Copier		18,974
Home Office Allocation		1,445
		<u>23,916</u>

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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

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

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

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

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

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

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

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A(1)	223	hrs	\$ 7,240		\$		223	\$ 7,240	1
2	Licensed Speech and Language Development Therapist	10A(1)	2307	hrs	113,903				2,307	113,903	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1)	3783	hrs	158,783				3,783	158,783	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				134,162		134,162	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				\$ 279,926		\$	\$ 134,162	6,313	\$ 414,088	14

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

This report must be completed even if f 234,734				
		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 89,553	\$ 89,553	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 140,000)	1,443,845	1,443,845	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	63,645	63,645	6
7	Other Prepaid Expenses	21,685	21,685	7
8	Accounts Receivable (owner: A/R-Prior Owner	736	736	8
9	Other(specify): Security Deposit	18,475	18,475	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,637,939	\$ 1,637,939	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		309,300	13
14	Buildings, at Historical Cost		2,072,069	14
15	Leasehold Improvements, at Historical Cost	25,204	27,665	15
16	Equipment, at Historical Cost	30,864	222,864	16
17	Accumulated Depreciation (book methods)	(13,049)	(345,153)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	577,000	591,323	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,885)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spec N/R-Mark Petersen	370,068	370,068	22
23	Other(specify): Independent Living Facility		628,546	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 990,087	\$ 3,865,797	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,628,026	\$ 5,503,736	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 766,553	\$ 766,553	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	799,022	799,022	29
30	Accrued Salaries Payable	126,694	126,694	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,528	6,528	31
32	Accrued Real Estate Taxes(Sch.IX-B)		143,616	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	89,259	89,259	36
37	Accrued Management Fees	75,520	75,520	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,863,576	\$ 2,007,192	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,859,280	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due To Related Parties	623,871	67,894	43
44	A/P-Other	334,636	334,636	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 958,507	\$ 3,261,810	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,822,083	\$ 5,269,002	46
47	TOTAL EQUITY(page 18, line 24)	\$ (194,057)	\$ 234,734	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,628,026	\$ 5,503,736	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (233,429)	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (233,429)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	457,933	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	(418,561)	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)	\$ 39,372	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)	\$ (194,057)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Mason Point**# **0050294**Report Period Beginning: **1/1/2012**Ending: **12/31/2012**

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,324,852	1
2	Discounts and Allowances for all Levels	(517,696)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,807,156	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	787,235	6
7	Oxygen	4,004	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 791,239	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	51,078	13
14	Non-Patient Meals	11,818	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	213,858	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	18,639	20
21	Other Medical Services	38,522	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 333,915	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	910	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 910	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous & Transportation Revenue	79,471	28
28a	Therapy Revenue From Related Parties	264,362	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 343,833	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,277,053	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,005,886	31
32	Health Care	3,106,699	32
33	General Administration	1,061,594	33
	B. Capital Expense		
34	Ownership	467,142	34
	C. Ancillary Expense		
35	Special Cost Centers	744,466	35
36	Provider Participation Fee	433,333	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,819,120	40
41	Income before Income Taxes (line 30 minus line 40)**	457,933	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 457,933	43

	1		2
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,013,929	44
45	Private Pay - Net Inpatient Revenue	2,362,180	45
46	Medicare - Net Inpatient Revenue	1,053,322	46
47	Other-(specify) Independent Living	381,967	47
48	Other-(specify) Insurance and Charity Therapy Allowance	(4,242)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,807,156	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? **No** If not, please attach a reconciliation.

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 66,713	\$ 32.07	1
2	Assistant Director of Nursing	2,080	2,080	54,082	26.00	2
3	Registered Nurses	5,259	5,458	133,318	24.43	3
4	Licensed Practical Nurses	30,040	31,346	636,156	20.29	4
5	CNAs & Orderlies	89,111	93,075	1,094,725	11.76	5
6	CNA Trainees					6
7	Licensed Therapist	6,313	6,313	279,926	44.34	7
8	Rehab/Therapy Aides	11,946	12,514	343,175	27.42	8
9	Activity Director	1,665	1,745	22,557	12.93	9
10	Activity Assistants	5,082	5,586	61,528	11.01	10
11	Social Service Workers	5,701	5,991	85,651	14.30	11
12	Dietician					12
13	Food Service Supervisor	2,636	2,663	37,801	14.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,280	35,010	322,394	9.21	15
16	Dishwashers					16
17	Maintenance Workers	11,191	11,646	197,505	16.96	17
18	Housekeepers	13,829	14,395	140,612	9.77	18
19	Laundry	13,216	13,725	124,612	9.08	19
20	Administrator	2,080	2,080	77,984	37.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	5,746	6,187	94,987	15.35	23
24	Clerical					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) See PG20A	14,200	14,560	212,160	14.57	33
34	TOTAL (lines 1 - 33)	256,455	266,454	\$ 3,985,886 *	\$ 14.96	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		\$		35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,000	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,000		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	9	227	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9	\$ 227		53

Mason Point
0010249
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	4,160	4,160	90,997	21.87
Restorative Aide	181	181	1,686	9.31
Transportation	7,779	8,139	81,248	9.98
Marketing	2,080	2,080	38,229	18.38
TOTAL	14,200	14,560	212,160	

STATE OF ILLINOIS

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount				
Darin Wall	Administrator	0	\$ 77,984	Workers' Compensation Insurance	\$ 66,150	IDPH License Fee	\$ 3,980				
				Unemployment Compensation Insurance	62,564	Advertising: Employee Recruitment	1,766				
				FICA Taxes	273,728	Health Care Worker Background Check					
				Employee Health Insurance	18,734	(Indicate # of checks performed)					
				Employee Meals		Patient Background Checks	22	224			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits		1,336			
				Employee Relations	26,142	Miscellaneous Dues & Subscriptions		946			
				Employee Retirement	2,914	Home Office Allocation		790			
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 77,984								
B. Administrative - Other											
Description			Amount								
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 270,200								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 270,200								
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
American Healthtech	Computer Services		\$ 1,691				Out-of-State Travel	\$			
Empower Software Solutions	Computer Services		1,583								
E-Health Data Solutions	Computer Services		1,460	N/A							
Ginoli and Company	Accounting Services		3,740				In-State Travel				
Honkamp Krueger & Co.	Accounting Services		4,844								
Allscripts	Computer Services		1,200								
Sorling , Northrup, Hanna	Legal Services		11,768								
Heart Technologies	Reverse 2011 Invoices		(4,889)				Seminar Expense				
Healthcare Resources Int'l	Legal Services		5,000								
							Home Office Allocation	19			
							Entertainment Expense	()			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 26,397				line 24, col. 8)	\$ 19			

* Attach copy of IMRF notifications

**See instructions.

Mason Point
0010249
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		26,397
Home Office Allocation		
Sorling Northrup	Legal	176
Ginoli & Company	Accountants	1,862
Miscellaneous	Computer Services	152
Nebo Systems	Computer Services	5
Advanced Answers on Demand	Computer Services	8567
Access 2 Go	Computer Services	360
Stratus Networks	Computer Services	355
Kemper Technology	Computer Services	585
CCH	Computer Services	31
Medifax	Computer Services	69
Vision Share/Ability Network	Computer Services	653
Barracuda	Computer Services	23
CIAN	Computer Services	178
Comcast	Computer Services	55
Postini	Computer Services	554
Optimizer Systems	Other Prof Fees	87
Marotta Gund Budd & Dzera	Other Prof Fees	39672
David Budde	Other Prof Fees	33
Courtney Bourban	Other Prof Fees	488
All Scripts	Other Prof Fees	1496
Heritage Enterprises	Other Prof Fees	35
Miscellaneous Vendors	Other Prof Fees	8
Total (agree to Schedule V, line 19, column 8)		<u>81,841</u>

Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility			
Vendor/Payee	Invoice Total	Allocation %	Total
Sorling Northrup	924.50	100%	925
Sorling Northrup	4,539.50	100%	4,540
Sorling Northrup	2,152.50	100%	2,153
Sorling Northrup	1,022.00	100%	1,022
Sorling Northrup	409.50	100%	410
Sorling Northrup	651.00	100%	651
Sorling Northrup	1,151.50	100%	1,152
Sorling Northrup	339.50	100%	340
Sorling Northrup	577.50	100%	578
Healthcare Resources International	5,000.00	100%	5,000
Home Office Allocation			
Sorling Northrup	5,053.00	3.48%	176
			-
Total Legal Fees			16,943

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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? N/A
- (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? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 37,248 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. N/A
- (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.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 433,333
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 11,818
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 50,425
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
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? N/A
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Mason Point
0010249
Period Beginning 1/1/2012
Period End 12/31/2012

Independent Living Offset

Schedule 23A

Census Days Summary:

	Days	%
Independent Living	18,200	24.40%
Nursing Home	56,382	75.60%
	74,582	100.00%

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	385,634	24.40%	94,095	Census	1
Food	284,886	24.40%	69,512	Census	2
Housekeeping	181,937	24.40%	44,393	Census	3
Laundry	170,457	24.40%	41,592	Census	4
Utilities	705,007	24.40%	172,022	Census	5
Maintenance	277,965	24.40%	67,823	Census	6
Depreciation (Building)	36,863	100.00%	36,863	Beds	30
Total	2,042,749		526,300		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on total number of beds.
Independent Living overhead and depreciation costs have been offset on P5A.

RECONCILIATION REPORT

Template

05:57 PM

6/13/2013

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,327,739	equal to	-1,327,739	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	229,851	equal to	229,851	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	181,118	equal to	181,118	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	117,412	equal to	117,412	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	23,916	equal to	23,916	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	279,926	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	623,101	equal to	623,101	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	134,162	equal to	134,162	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,005,886	equal to	2,005,886	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	3,106,699	equal to	3,106,699	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,061,594	equal to	1,061,594	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	467,142	equal to	467,142	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	744,466	equal to	744,466	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38to41+43	4
Income Stat. Prov. Partic.	433,333	equal to	433,333	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,077,677	equal to	2,077,677	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	279,926	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	165,333	equal to	165,333	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	85,651	equal to	85,651	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	360,195	equal to	360,195	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	197,505	equal to	197,505	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	140,612	equal to	140,612	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	124,612	equal to	124,612	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	77,984	equal to		0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	94,987	equal to	94,987	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,985,886	equal to	3,907,902	77,984	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,000	< or = to	9,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,227	< or = to	12,642	-8,415	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	-1,023	1,023	FAILED	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	77,984	equal to		0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	270,200	equal to	270,200	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	26,397	equal to	26,397	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	450,232	equal to	450,232	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	8,454	equal to	8,454	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	19	equal to	19	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	433,333	equal to	433,333	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	-32,736	32,736	FAILED	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	6,787	equal to	6,787	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	173,974	equal to	173,974	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	3,658,302	equal to	3,658,302	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	143,616	equal to	143,616	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	309,300	equal to	309,300	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,099,734	equal to	2,099,734	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	222,864	equal to	222,864	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	345,153	equal to	345,153	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-194,057	equal to	-194,057	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	457,933	equal to	457,933	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..J33	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,628,026	equal to	2,628,026	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	360,195	25,439	0	385,634	0	385,634	-83,831	301,803
2. Food Purchase	0	284,886	0	284,886	0	284,886	-80,984	203,902
3. Housekeeping	140,612	41,325	0	181,937	0	181,937	-44,314	137,623
4. Laundry	124,612	45,845	0	170,457	0	170,457	-41,578	128,879
5. Heat and Other Utilities	0	0	705,007	705,007	0	705,007	-198,164	506,843
6. Maintenance	197,505	27,419	53,041	277,965	0	277,965	-62,129	215,836
7. Other (specify)*	0	0	0	0	0	0	1,367	1,367
8. Total General Services	822,924	424,914	758,048	2,005,886	0	2,005,886	-509,633	1,496,253
9. Medical Director	0	0	9,000	9,000	0	9,000	0	9,000
10. Nursing & Medical Records	2,077,677	133,223	12,642	2,223,542	0	2,223,542	99	2,223,641
10a. Therapy	623,101	0	0	623,101	0	623,101	-231,626	391,475
11. Activities	165,333	729	-1,023	165,039	0	165,039	-50,425	114,614
12. Social Services	85,651	366	0	86,017	0	86,017	0	86,017
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,951,762	134,318	20,619	3,106,699	0	3,106,699	-281,952	2,824,747
17. Administrative	0	0	270,200	270,200	0	270,200	-192,216	77,984
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	26,397	26,397	0	26,397	55,444	81,841
20. Fees, Subscriptions & Promotion	0	0	8,252	8,252	0	8,252	202	8,454
21. Clerical & General Office	94,987	19,210	46,316	160,513	0	160,513	115,172	275,685
22. Employee Benefits & Payroll	0	0	482,968	482,968	0	482,968	-32,736	450,232
23. Inservice Training & Education	0	0	867	867	0	867	194	1,061
24. Travel and Seminar	0	0	0	0	0	0	19	19
25. Other Admin. Staff Trans	0	0	46,308	46,308	0	46,308	13,313	59,621
26. Insurance-Prop.Liab.Malpractice	0	0	66,089	66,089	0	66,089	2,194	68,283
27. Other (specify)*	0	0	0	0	0	0	27,409	27,409
28. Total General Adminis	94,987	19,210	947,397	1,061,594	0	1,061,594	-11,005	1,050,589
29. Total General Administrative	3,869,673	578,442	1,726,064	6,174,179	0	6,174,179	-802,590	5,371,589
30. Depreciation	0	0	6,253	6,253	0	6,253	111,159	117,412
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	38,339	38,339	0	38,339	191,512	229,851
33. Real Estate	0	0	0	0	0	0	181,118	181,118

34. Rent - Facility & Grounds	0	0	400,079	400,079	0	400,079	-400,079	0
35. Rent - Equipment & Vehicles	0	0	22,471	22,471	0	22,471	1,445	23,916
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	467,142	467,142	0	467,142	85,155	552,297
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	134,162	0	134,162	0	134,162	0	134,162
40. Barber and Beauty Shop	0	0	1,326	1,326	0	1,326	-1,326	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	433,333	433,333	0	433,333	0	433,333
43. Other (specify):*	38,229	7,216	563,533	608,978	0	608,978	-608,978	0
44. Total Special Cost Ce	38,229	141,378	998,192	1,177,799	0	1,177,799	-610,304	567,495
45. Grand Total	3,907,902	719,820	3,191,398	7,819,120	0	7,819,120	-1,327,739	6,491,381

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	89,553	89,553
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,443,845	1,443,845
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	63,645	63,645
7. Other Prepaid Expenses	21,685	21,685
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	19,211	19,211
10. Total current assets	1,637,939	1,637,939
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	390,000
14. Buildings, at Historical Cost	0	2,679,369
15. Leasehold Improvements, Historical Cost	25,204	27,665
16. Equipment, at Historical Cost	30,864	310,864
17. Accumulated Depreciation (book methods)	-13,049	-492,607
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	577,000	591,323
20. Accum Amort - Org/Pre-Op Costs	0	-10,885
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	620,019	3,495,729
25. Total Assets	2,257,958	5,133,668
CURRENT LIABILITIES		
26. Accounts Payable	766,553	766,553
27. Officer's Accounts Payable	-370,068	-370,068
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	799,022	799,022
30. Accrued Salaries Payable	126,694	126,694
31. Accrued Taxes Payable	6,528	6,528
32. Accrued Real Estate Taxes	0	143,616
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	89,259	89,259

37. Other Current Liabilities (specify):	75,520	75,520
38. Total Current Liabilities	1,493,508	1,637,124
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	2,859,280
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	958,507	402,530
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	958,507	3,261,810
46.Total Liabilities	2,452,015	4,898,934
47.Total Equity	-194,057	234,734
48.Total Liabilities and Equity	2,257,958	5,133,668

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	7,324,852
2. Discounts and Allowances for all Levels	-517,696
Subtotal - Inpatient Care	6,807,156
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	787,235
7. Oxygen	4,004
Subtotal - Anciliary Revenue	791,239
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	51,078
14. Non-Patient Meals	11,818
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	213,858
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	18,639
21. Other Medical Services	38,522
22. Laundry	0
Subtotal - Other Operating Revenue	333,915
24. Contributions	0
25. Interest and Other Investments Income	910
Subtotal - Non-Operating Revenue	910
27. Other Revenue (specify):	0
28. Other Revenue (specify):	343,833
Subtotal - Other Revenue	343,833
30. Total Revenue	8,277,053
31. General Services	1,968,111
32. Health Care	3,041,119
33. General Administration	1,061,356
34. Ownership	408,649

35. Special Cost Centers	263,203
35. Provider Participation Fee	66,795
37. Other	0
40. Total Expenses	6,809,233
41. Income Before Income Taxes	1,467,820
42. Income Taxes	0
43. Net Income or Loss for the Year	1,467,820

Enter Cost Center Expenses

**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED
TO THE COST REPORT!!!!** 6/13/2013

6/13/2013

05:57:23 PM

HSA Number: _____ 4 Name: **Mason Point**

Cost report period	From:	<u>1/1/2012</u>	To:	<u>12/31/2012</u>	Base Number:	444
If this is an ICF/DD 16 facility, enter a 1 in cell C6		<u>N</u>				

Licensed bed days:	62,050	Occupancy:	56,382	Pct. of occupancy:	90.87%
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Illinois Public Aid Support Rate: \$ _____

Genl Services Salary/Wage: 822,924 Col 1, Line 8 ---Audit Adj: _____

Genl Admin Salary/Wage: 94,987 Col 1, Line 28 ---Audit Adj: _____

Total Salary Wage: 3,907,902 Col 1, Line 44 ---Audit Adj: _____

Employee Benefits: 450,232 Col 8, Line 22 ---Audit Adj:

Total General Services: 1,496,253 Col 8, Line 8 ---Audit Adj:

Total General Admin: 1,050,589 Col 8, Line 28 ---Audit Adj:

Instructions and Calculation Steps

STEP 1

Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A.

General Services

- 1 Determine the proportion of general services wages to total wages.
- 2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.
- 3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B.

General Administration

- 1 Determine the proportion of General Administration wages to total wages.
- 2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.
- 3 Add the proportioned fringe amount to your total General Administration expenses.
- 4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)
Allocation of Emplayee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month = 13 divided by 2 =
Beginning Day + Ending Day = 32 divided by 60.8 =
Beginning Year + Ending Year = 224 multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost
(from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is
equal to or above 93 percent, divide your total updated
support costs (Step II, C, 3, above) by the total patient
days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent
of the licensed bed days (Cost Report, Page 2, Schedule III-A,
Column 4, Line 7). Then subtract the total patient
days (Cost Report, Page 2, Schedule III-B, Column 5,
Line 14) from the result and calculate one-third of the
difference. Then add the one-third difference to the total
patient days to obtain your adjusted occupancy. Next
divide your total updated Support Costs (Step II, C, 3 above)
by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupany

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

- A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.
- B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

- C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus \$.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is
35th Percentile is

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

\$822,924
\$3,907,902
21.0579%
\$450,232
\$94,809
\$1,496,253
\$1,591,062

\$94,987
\$3,907,902
2.4306%

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

\$450,232
\$10,943
\$1,050,589
\$450,232
\$611,300

6.5
0.526315789
1344
1351.026316
907.00
444

1
1

\$1,591,062
1

\$1,591,062

\$611,300
<u>1</u>
\$611,300
<u>\$2,202,362</u>

\$38.76

\$2,202,362
<u>56,382</u>
<u>\$39.06</u>

62,050
<u>0.93</u>
57,707
<u>56,382</u>
1,325
442
<u>56,382</u>
<u>56,824</u>

\$2,202,362

56824

\$38.76

\$47.44

\$38.76

\$8.68

0.5

\$4.34

\$38.76

43.1

\$47.44

\$38.76

\$8.68

0.5
<u>\$4.34</u>
<u>3.795</u>
\$3.795
<u>\$38.76</u>
\$42.56
<u><u>\$42.56</u></u>
\$47.44
\$39.95

7/DD 16 Facilities)
centiles by HSA
Not updated with current figures

75th Percentile	35th Percentile	Below 35th Profit Ceiling
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655