

		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0050294

Facility Name: Mason Point

Address: One Masonic Way Sullivan 61951
Number City Zip Code

County: Moultrie

Telephone Number: (217) 728-4394 Fax # (217) 728-4221

HFS ID Number:

Date of Initial License for Current Owners: 1/1/2009

Type of Ownership:

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

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

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Mason Point

0050294 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

N/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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,986</u>	<u>10,982</u>	<u>3,670</u>	<u>16,638</u>	8
9	SNF/PED					9
10	ICF	<u>18,250</u>			<u>18,250</u>	10
11	ICF/DD					11
12	SC		<u>3,373</u>		<u>3,373</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,236</u>	<u>14,355</u>	<u>3,670</u>	<u>38,261</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 61.66%

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)

Independent Living

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 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 3,114

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	405,371	26,081		431,452		431,452	(107,126)	324,326			1
2	Food Purchase		307,012		307,012		307,012	(87,172)	219,840			2
3	Housekeeping	168,561	58,249		226,810		226,810	(60,309)	166,501			3
4	Laundry	82,633	18,979		101,612		101,612	(95,720)	5,892			4
5	Heat and Other Utilities			766,807	766,807		766,807	(228,453)	538,354			5
6	Maintenance	287,727	31,474	50,389	369,590		369,590	(96,057)	273,533			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	944,292	441,795	817,196	2,203,283		2,203,283	(674,837)	1,528,446			8
	B. Health Care and Programs											
9	Medical Director			9,300	9,300		9,300		9,300			9
10	Nursing and Medical Records	2,346,882	165,302	14,627	2,526,811		2,526,811	(14,826)	2,511,985			10
10a	Therapy			461,075	461,075		461,075		461,075			10a
11	Activities	222,991	475	1,452	224,918		224,918	(113,469)	111,449			11
12	Social Services	72,094	62		72,156		72,156		72,156			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	2,641,967	165,839	486,454	3,294,260		3,294,260	(128,295)	3,165,965			16
	C. General Administration											
17	Administrative			460,100	460,100		460,100	(376,731)	83,369			17
18	Directors Fees											18
19	Professional Services			31,907	31,907		31,907	20,014	51,921			19
20	Dues, Fees, Subscriptions & Promotions			10,420	10,420		10,420	(51)	10,369			20
21	Clerical & General Office Expenses	80,568	5,502	60,815	146,885		146,885	91,247	238,132			21
22	Employee Benefits & Payroll Taxes			541,972	541,972		541,972	51,231	593,203			22
23	Inservice Training & Education			1,595	1,595		1,595	176	1,771			23
24	Travel and Seminar							85	85			24
25	Other Admin. Staff Transportation			11,413	11,413		11,413	7,208	18,621			25
26	Insurance-Prop.Liab.Malpractice			57,655	57,655		57,655	1,015	58,670			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	80,568	5,502	1,175,877	1,261,947		1,261,947	(205,806)	1,056,141			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,666,827	613,136	2,479,527	6,759,490		6,759,490	(1,008,938)	5,750,552			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			29,937	29,937		29,937	114,092	144,029			30
31	Amortization of Pre-Op. & Org.							8,275	8,275			31
32	Interest			23,784	23,784		23,784	145,688	169,472			32
33	Real Estate Taxes							242,099	242,099			33
34	Rent-Facility & Grounds			7,429	7,429		7,429	(7,429)				34
35	Rent-Equipment & Vehicles			26,334	26,334		26,334	1,648	27,982			35
36	Other (specify):*											36
37	TOTAL Ownership			87,484	87,484		87,484	504,373	591,857			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,335		109,335		109,335		109,335			39
40	Barber and Beauty Shops			1,450	1,450		1,450	(1,450)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			257,571	257,571		257,571		257,571			42
43	Other (specify):*	19,944	1,027	238,027	258,998		258,998	(258,998)				43
44	TOTAL Special Cost Centers	19,944	110,362	497,048	627,354		627,354	(260,448)	366,906			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,686,771	723,498	3,064,059	7,474,328		7,474,328	(765,013)	6,709,315			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,494)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,226)	43		5
6	Rented Facility Space	(1,750)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,989	30		9
10	Interest and Other Investment Income	(13)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(640)	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	(165,803)	43		18
19	Entertainment				19
20	Contributions	(37,500)	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				24
25	Fund Raising, Advertising and Promotional	(4,746)	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	(891,436)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,105,619)		\$	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)	340,606	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 340,606		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (765,013)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (8,906)	43	1
2	X-Rays-Part A	(8,828)	43	2
3	Offset Privately Paid Electricity	(24,552)	5	3
4	Offset Transportation Revenue	(113,469)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(280)	21	5
6	Offset Chamber of Commerce Dues	(888)	20	6
7	Offset Miscellaneous Nursing Supplies Revenue	(15,059)	10	7
8	Offset Miscellaneous Laundry Supplies Revenue	(68,640)	4	8
9	Disallowed Special Events	(904)	43	9
10	Pet Expense	(1,415)	43	10
11	Offset Independent Living Depreciation	(24,292)	30	11
12	Offset Independent Living Dietary	(114,985)	1	12
13	Offset Independent Living Food	(81,821)	2	13
14	Offset Independent Living Housekeeping	(60,446)	3	14
15	Offset Independent Living Laundry	(27,080)	4	15
16	Offset Independent Living Utilities	(204,359)	5	16
17	Offset Independent Living Maintenance	(98,498)	6	17
18	Offset Privately Paid Telephone	(94)	21	18
19	Disallow Marketing Expense	(19,944)	43	19
20	Offset Barber and Beauty Revenue	(1,450)	40	20
21	Resident Flowers	(86)	43	21
22	Offset Escrow Refund	(15,340)	32	22
23	Offset Miscellaneous Mainteance Supplies Revenue	(100)	6	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	(891,436)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mason Point# 0050294

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	(114,985)	7,859	0	0	0	0	0	0	0	0	0	(107,126)	1
2	Food Purchase	(87,315)	143	0	0	0	0	0	0	0	0	0	(87,172)	2
3	Housekeeping	(60,446)	137	0	0	0	0	0	0	0	0	0	(60,309)	3
4	Laundry	(95,720)	0	0	0	0	0	0	0	0	0	0	(95,720)	4
5	Heat and Other Utilities	(228,911)	458	0	0	0	0	0	0	0	0	0	(228,453)	5
6	Maintenance	(100,348)	4,291	0	0	0	0	0	0	0	0	0	(96,057)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(687,725)	12,888	0	0	0	0	0	0	0	0	0	(674,837)	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	(15,059)	233	0	0	0	0	0	0	0	0	0	(14,826)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(113,469)	0	0	0	0	0	0	0	0	0	0	(113,469)	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	(128,528)	233	0	0	0	0	0	0	0	0	0	(128,295)	16
	C. General Administration													
17	Administrative	0	(376,731)	0	0	0	0	0	0	0	0	0	(376,731)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	20,014	0	0	0	0	0	0	0	0	0	20,014	19
20	Fees, Subscriptions & Promotions	(888)	0	837	0	0	0	0	0	0	0	0	(51)	20
21	Clerical & General Office Expenses	(374)	0	91,621	0	0	0	0	0	0	0	0	91,247	21
22	Employee Benefits & Payroll Taxes	0	0	51,231	0	0	0	0	0	0	0	0	51,231	22
23	Inservice Training & Education	0	0	176	0	0	0	0	0	0	0	0	176	23
24	Travel and Seminar	0	0	85	0	0	0	0	0	0	0	0	85	24
25	Other Admin. Staff Transportation	0	0	7,208	0	0	0	0	0	0	0	0	7,208	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,015	0	0	0	0	0	0	0	0	1,015	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,262)	(356,717)	152,173	0	0	0	0	0	0	0	0	(205,806)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(817,515)	(343,596)	152,173	0	0	0	0	0	0	0	0	(1,008,938)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(12,303)	0	20,275	106,120	0	0	0	0	0	0	0	114,092	30
31	Amortization of Pre-Op. & Org.	0	0	0	8,275	0	0	0	0	0	0	0	8,275	31
32	Interest	(15,353)	0	596	160,445	0	0	0	0	0	0	0	145,688	32
33	Real Estate Taxes	0	0	467	241,632	0	0	0	0	0	0	0	242,099	33
34	Rent-Facility & Grounds	0	0	0	(7,429)	0	0	0	0	0	0	0	(7,429)	34
35	Rent-Equipment & Vehicles	0	0	1,648	0	0	0	0	0	0	0	0	1,648	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(27,656)	0	22,986	509,043	0	0	0	0	0	0	0	504,373	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	(1,450)	0	0	0	0	0	0	0	0	0	0	(1,450)	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):*	(258,998)	0	0	0	0	0	0	0	0	0	0	(258,998)	43
44	TOTAL Special Cost Centers	(260,448)	0	0	0	0	0	0	0	0	0	0	(260,448)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,105,619)	(343,596)	175,159	509,043	0	0	0	0	0	0	0	(765,013)	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
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

☒

YES

☐

NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 7,859	\$ 7,859	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	143	143	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	137	137	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	458	458	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	4,291	4,291	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	233	233	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	460,100	Petersen Health Care Management, Inc.	100.00%	83,369	(376,731)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	20,014	20,014	12
13	V								13
14	Total			\$ 460,100			\$ 116,504	\$ * (343,596)	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: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 837	\$ 837	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	91,621	91,621	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	51,231	51,231	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	176	176	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	85	85	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	7,208	7,208	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,015	1,015	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	20,275	20,275	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	596	596	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	467	467	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,648	1,648	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		\$			\$ 175,159	\$ * 175,159	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	19	Professional Services	\$	Petersen VII, LLC	100.00%	\$	\$	15
16	V	26	Insurance-Property		Petersen VII, LLC	100.00%			16
17	V	26	Insurance-MIP		Petersen VII, LLC	100.00%			17
18	V	30	Depreciation		Petersen VII, LLC	100.00%	106,120	106,120	18
19	V	31	Amortization		Petersen VII, LLC	100.00%	8,275	8,275	19
20	V	32	Interest		Petersen VII, LLC	100.00%	160,445	160,445	20
21	V	33	Real Estate Taxes		Petersen VII, LLC	100.00%	241,632	241,632	21
22	V	34	Rent-Income and Grounds	7,429	Petersen VII, LLC	100.00%	0	(7,429)	22
23	V								23
24	V								24
25	V								25
26	V								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			\$ 7,429			\$ 516,472	\$ * 509,043	39

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

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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 Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	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	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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:

1/1/2016

Ending:

12/31/2016

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			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				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 Point # 0050294 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	N/A										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 Point# 0050294

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	38,261	\$ 7,859	1
2	2	Food	Resident Days	75	5,673	0	38,261	143	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	38,261	137	3
4	5	Utilities	Resident Days	75	18,209	0	38,261	458	4
5	6	Maintenance	Resident Days	75	170,632	137,057	38,261	4,291	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	38,261	0	6
7	9	Medical Director	Resident Days	75	0	0	38,261	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	38,261	233	8
9	10A	Therapy	Resident Days	75	0	0	38,261	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	38,261	0	10
11	17	Administrative	Resident Days	75	4,806,228	5,473,961	38,261	83,369	11
12	19	Professional Services	Resident Days	75	795,918	0	38,261	20,014	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	38,261	837	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	38,261	91,621	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	38,261	51,231	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	38,261	176	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	38,261	85	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	38,261	7,208	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	38,261	1,015	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	38,261	0	20
21	30	Depreciation	Resident Days	75	806,271	0	38,261	20,275	21
22	32	Interest	Resident Days	75	23,686	0	38,261	596	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	38,261	467	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	38,261	1,648	24
25	TOTALS				\$ 13,089,501	\$ 11,510,481		\$ 291,663	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank Leumi		X	Mortgage	Varies	5/20/2016	\$ 3,300,000	\$ 3,000,979	5/19/2041	Varies	\$ 160,445	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Bank Leumi		X	Working Capital	Varies	7/28/2016	1,200,000	1,165,690	7/28/2017	Varies	23,784	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,500,000	\$ 4,166,669			\$ 184,229	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(13)	10	
11								Home Office Allocation-PHCM			596	11	
12								Escrow Refund			(15,340)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (14,757)	14	
15	TOTALS (line 9+line14)						\$ 4,500,000	\$ 4,166,669			\$ 169,472	15	

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

FACILITY NAME Mason Point COUNTY Moultrie
FACILITY IDPH LICENSE NUMBER 0050294
CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER
TELEPHONE (309)689-5850 FAX #: (309)691-8622

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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.)

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 BrickFrame Metal Masonry

Number of Stories Bldgs. Vary 1,2, or 3

C. Does the Operating Entity? X(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? X(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).

Independent Living, Apartment Units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? X YES NO

If so, please complete the following:

1. Total Amount Incurred: 126,071

2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 8,275

4. Dates Incurred: 2015-2016

Nature of Costs:

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

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	1,568,160		2009		\$ 309,300	
2							
3	TOTALS	1,568,160				\$ 309,300	

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	\$ 613,710	4
5	24			1955							5
6	72			1983							6
7	50			1986							7
8	48			1981							8
	Improvement Type**										
9	Generator Repair			2009	2,936		7	206	206	2,936	9
10	Automatic Door Opener/Closer			2010	8,185		15	546	546	3,549	10
11	Roof Repairs			2011	9,265		7	1,321	1,321	9,265	11
12	Elevator Repair			2012	4,817		7	688	688	3,096	12
13	Water Tower Repair			2013	2,725		7	390	390	1,365	13
14	Door Restrictors			2014	10,346		7	1,478	1,478	3,695	14
15	Door Restrictors			2015	10,346		7	1,478	1,478	2,217	15
16	Generator Repair			2015	9,464		7	1,352	1,352	2,028	16
17	Elevator Repair			2015	8,380		7	1,198	1,198	1,797	17
18	Elevator Repair			2015	2,810		7	402	402	603	18
19	Wall Painting-Auditorium, Hallways, Back Rooms			2016	16,977		15	566	566	566	19
20	Tiling Replacement-Hallways, Common Area			2016	10,012		10	501	501	501	20
21	Water Heater			2016	2,920		7	209	209	209	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					11,186			(11,186)		32
33											33
34	2016-Home Office Allocation-Building Improvements				16,892			405	405		34
35	2016-Home Office Allocation-Land Improvements				1,554			101	101		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 Point

0050294

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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
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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)		\$ 2,163,329	\$ 93,014		\$ 92,669	\$ (345)	\$ 645,537	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	\$285,630	\$14,499	\$28,564	\$14,065	5-10 yrs.	\$178,093	71
72	Current Year Purchases	35,371	3,252	2,527	(725)	7 yrs.	2,527	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			19,769	19,769			74
75	TOTALS	\$321,001	\$17,751	\$50,860	\$33,109		\$180,620	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	Facility	2007 Ford E-150 Van	2006	\$5,000	\$1,000	\$500	\$(500)	5 yrs.	\$500	76
77										77
78										78
79										79
80	TOTALS			\$5,000	\$1,000	\$500	\$(500)		\$500	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)	\$2,798,630	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$111,765	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$144,029	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$32,264	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$826,657	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	\$24,292	\$282,336	86
87					87
88					88
89					89
90					90
91	TOTALS	\$776,000	\$24,292	\$282,336	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94	N/A		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. YESNO

		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: YESNO Terms: *

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

15. Is Movable equipment rental included in building rental? YESNO
16. Rental Amount for movable equipment: \$27,982Description: 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	N/A				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.

Mason Point
0050294
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

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

Medical Equipment	\$	16,436
Dishwasher		701
Copier		9,197
Home Office Allocation		<u>1,648</u>
		<u><u>27,982</u></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

ALLOCATION OF COSTS (d)

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

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

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

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

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	11,126	\$ 166,894	\$	11,126	\$ 166,894	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		6,146	92,186		6,146	92,186	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		13,466	201,995		13,466	201,995	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				109,335		109,335	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	30,738	\$ 461,075	\$ 109,335	30,738	\$ 570,410	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.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (214,363)	\$ (214,363)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 123,162)	1,767,587	1,767,587	3
4	Supply Inventory (priced at Cost)	21,685	21,685	4
5	Short-Term Investments			5
6	Prepaid Insurance	51,242	51,242	6
7	Other Prepaid Expenses	44,393	44,393	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany Loans	907	1,314,183	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,671,451	\$ 2,984,727	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		2,062,592	14
15	Leasehold Improvements, at Historical Cost	99,183	100,737	15
16	Equipment, at Historical Cost	134,001	326,001	16
17	Accumulated Depreciation (book methods)	(88,815)	(826,657)	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) Goodwill	577,000	577,000	22
23	Other(specify): Independent Living Facility		493,664	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 721,369	\$ 3,042,637	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,392,820	\$ 6,027,364	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,549,746	\$ 1,549,746	26
27	Officer's Accounts Payable	(231,143)	(231,143)	27
28	Accounts Payable-Patient Deposits	109,673	109,673	28
29	Short-Term Notes Payable	1,165,690	1,165,690	29
30	Accrued Salaries Payable	132,466	132,466	30
31	Accrued Taxes Payable (excluding real estate taxes)	458,554	458,554	31
32	Accrued Real Estate Taxes(Sch.IX-B)		454,916	32
33	Accrued Interest Payable	5,167	5,167	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	8,090	8,090	36
37	Accrued Management Fees	37,650	37,650	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,235,893	\$ 3,690,809	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,000,979	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	146,520	146,520	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 146,520	\$ 3,147,499	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,382,413	\$ 6,838,308	46
47	TOTAL EQUITY(page 18, line 24)	\$ (989,593)	\$ (810,944)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,392,820	\$ 6,027,364	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (577,949)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Reports Were Filed	(87,001)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (664,950)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(266,031)	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	(58,612)	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)	\$ (324,643)	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)	\$ (989,593)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mason Point

0050294

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 6,027,908	1
2	Discounts and Allowances for all Levels	(391,500)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,636,408	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	222,961	5
6	Therapy	839,855	6
7	Oxygen	3,623	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,066,439	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	32,199	13
14	Non-Patient Meals	5,494	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,750	16
17	Sale of Drugs	172,773	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	16,022	20
21	Other Medical Services	39,665	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 267,903	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	113,469	28
28a	<u>Miscellaneous Revenue</u>	124,065	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 237,534	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,208,297	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,203,283	31
32	Health Care	3,294,260	32
33	General Administration	1,261,947	33
	B. Capital Expense		
34	Ownership	87,484	34
	C. Ancillary Expense		
35	Special Cost Centers	369,783	35
36	Provider Participation Fee	257,571	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,474,328	40
41	Income before Income Taxes (line 30 minus line 40)**	(266,031)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (266,031)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,603,414	44
45	Private Pay - Net Inpatient Revenue	2,204,334	45
46	Medicare - Net Inpatient Revenue	688,048	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	140,612	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,636,408	49

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

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

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

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

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,761	2,761	\$ 79,708	\$ 28.87	1
2	Assistant Director of Nursing	2,239	2,287	60,040	26.25	2
3	Registered Nurses	10,042	10,257	260,004	25.35	3
4	Licensed Practical Nurses	22,849	24,579	509,032	20.71	4
5	CNAs & Orderlies	94,870	99,658	1,226,952	12.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,040	1,040	25,447	24.47	8
9	Activity Director	1,418	1,482	22,544	15.21	9
10	Activity Assistants	6,698	7,683	97,326	12.67	10
11	Social Service Workers	5,164	5,435	72,094	13.26	11
12	Dietician					12
13	Food Service Supervisor	3,136	3,136	45,680	14.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,752	33,711	359,691	10.67	15
16	Dishwashers					16
17	Maintenance Workers	15,709	16,263	287,727	17.69	17
18	Housekeepers	17,487	17,859	168,561	9.44	18
19	Laundry	7,370	7,582	82,633	10.90	19
20	Administrator	2,080	2,080	83,369	40.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,961	4,130	80,568	19.51	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	987	987	23,607	23.92	31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	20,010	20,805	285,157	13.71	33
34	TOTAL (lines 1 - 33)	250,573	261,735	\$ 3,770,140 *	\$ 14.40	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		\$	L1, C3	35
36	Medical Director	Monthly	9,300	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,000	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)		\$ 15,300		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 480	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	\$ 480		53

Mason Point
0050294
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	6,585	6,857	162,092	23.64
Transportation	11,827	12,255	103,121	8.41
Marketing	1,598	1,693	19,944	11.78
TOTAL	20,010	20,805	285,157	

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darin Wall	Administrator	0	\$ 83,369
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 83,369

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	\$ 460,100
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 460,100

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	\$ 3,043
Moore, Susler, McNutt, Wrigley	Legal Fees	1,030
Marotta, Gund, Budd, & Dzera	Consulting Fees	16,000
Ginoli and Company	Accounting Services	1,095
Honkamp Krueger & Co.	Accounting Services	705
DJ Howard & Associates	Appraisal Services	2,200
One-Eleven Internet Service	Computer Services	979
Allscripts	Data Services	961
Shawnee Communications	Computer Services	280
Bank Leumi	Loan closing fees	5,614
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 31,907

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 197,606
Unemployment Compensation Insurance	51,924
FICA Taxes	270,319
Employee Health Insurance	14,732
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	5,399
Employee Retirement	1,991
Home Office Allocation	51,231
TOTAL (agree to Schedule V, line 22, col.8)	\$ 593,203

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
N/A		
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	1,573
Health Care Worker Background Check (Indicate # of checks performed 125)	1,390
Patient Background Checks 16	172
Miscellaneous Licenses & Permits	2,598
Miscellaneous Dues & Subscriptions	2,697
Home Office Allocation	837
Less: Public Relations Expense	(888)
Non-allowable advertising (	
Yellow page advertising (	
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,369

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Home Office Allocation	85
Entertainment Expense (	
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 85

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Mason Point
0050294
Period Beginning1/1/2016
Period End12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		31,907
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	89
Miscellaneous	Legal	31
Miller Hall and Triggs	Legal	155
Healthcare Resources International	Legal	771
Hunziker Law	Legal	184
Lexis Nexis	Legal	16
CliftonLarson Allen	Accountants	802
Ginoli & Co.	Accountants	2,620
Miscellaneous	Computer Services	102
Change Healthcare	Computer Services	15
PTC Select	Computer Services	9
Advanced Answers on Demand	Computer Services	7,046
Stratus Networks	Computer Services	717
Kemper Technology	Computer Services	472
AT&T	Computer Services	10
Ability Network	Computer Services	3,004
CIAN	Computer Services	358
Comcast	Computer Services	58
CCH	Computer Services	24
Charter Communications	Computer Services	70
Allscripts	Computer Services	1,048
ATS	Computer Services	473
Allpayer Exchange	Computer Services	24
Optimizer	Other Prof Fees	72
Ankura	Other Prof Fees	547
David Budde	Other Prof Fees	62
Bruner, Cooper, Zuck	Other Prof Fees	159
Marotta, Gund, Budd, Dzerda	Other Prof Fees	984
Professional Software and Services	Other Prof Fees	39
Hughes Valuation Services	Other Prof Fees	49
Alan Litwiller	Other Prof Fees	4

Total (agree to Schedule V, line 19, column 8)51,921

Mason Point
0050294
Period Beginning1/1/2016
Period End12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PHC II & PHCM

Lucie, Scalf, and Bougher	Legal	89
Miscellaneous	Legal	31
Miller Hall and Triggs	Legal	155
Healthcare Resources International	Legal	771
Hunziker Law	Legal	184
Lexis Nexis	Legal	16

Direct Facility Invoices

Moore, Susler, McNutt & Wrigley	8/23/2016	1,030
Bank Leumi-Loan Closing Fees	7/29/2016	5,614

Total Legal Fees (agree to Schedule V, line 19, column 8)7,890

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
IHCA \$1000
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 42,558 Line 10
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 257,571
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes Indicate the amount. \$ 4,939
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
\$ 113,469

c.

What percent of all travel expense relates to transportation of nurses and patients?

100

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?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli and Company

(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.
Attach invoices and a summary of services for all architect and appraisal fees

Yes

Mason Point
0050294
Period Beginning 1/1/2016
Period End 12/31/2016

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	14,248	26.65%
Nursing Home	38,261	71.57%
	53,462	100.00%

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	431,452	26.65%	114,985	Census	1
Food	307,012	26.65%	81,821	Census	2
Housekeeping	226,810	26.65%	60,446	Census	3
Laundry	101,612	26.65%	27,080	Census	4
Utilities	766,807	26.65%	204,359	Census	5
Maintenance	369,590	26.65%	98,498	Census	6
Depreciation (Building)	24,292	100.00%	24,292	Beds	30
Total	2,227,575		611,482		

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.

RECONCILIATI Mason Point

11:07 AM 7/7/2017

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 Detr	-765,013	equal to	-765,013	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	169,472	equal to	169,472	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	242,099	equal to	242,099	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exj	8,275	equal to	8,275	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	144,029	equal to	144,029	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	27,982	equal to	27,982	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service	461,075	equal to	461,075	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	109,335	equal to	109,335	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	2,203,283	equal to	2,203,283	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	3,294,260	equal to	3,294,260	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	1,261,947	equal to	1,261,947	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	87,484	equal to	87,484	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	369,783	equal to	369,783	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Pr	257,571	equal to	257,571	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,346,882	equal to	2,346,882	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aidi	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	222,991	equal to	222,991	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Sei	72,094	equal to	72,094	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	405,371	equal to	405,371	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	287,727	equal to	287,727	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	168,561	equal to	168,561	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	82,633	equal to	82,633	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administr	83,369	equal to	83,369	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	80,568	equal to	80,568	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	3,770,140	equal to	3,686,771	83,369	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consult	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,300	< or = to	9,300	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	6,480	< or = to	14,627	-8,147	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consult	0	< or = to	1,452	-1,452	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	83,369	equal to	83,369	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	460,100	equal to	460,100	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	31,907	equal to	31,907	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	593,203	equal to	593,203	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	10,369	equal to	10,369	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	85	equal to	85	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	257,571	equal to	257,571	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medical	3,114	equal to	3,670	-556	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	340,606	equal to	340,606	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	4,166,669	equal to	4,166,669	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax i	454,916	equal to	454,916	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	2,163,329	equal to	2,163,329	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and i	326,001	equal to	326,001	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	826,657	equal to	826,657	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	-989,593	equal to	-989,593	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	-266,031	equal to	-266,031	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,392,820	equal to	2,392,820	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	405,371	26,081	0	431,452	0	431,452	-107,126	324,326
2. Food Purchase	0	307,012	0	307,012	0	307,012	-87,172	219,840
3. Housekeeping	168,561	58,249	0	226,810	0	226,810	-60,309	166,501
4. Laundry	82,633	18,979	0	101,612	0	101,612	-95,720	5,892
5. Heat and Other Utilities	0	0	766,807	766,807	0	766,807	-228,453	538,354
6. Maintenance	287,727	31,474	50,389	369,590	0	369,590	-96,057	273,533
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	944,292	441,795	817,196	2,203,283	0	2,203,283	-674,837	#####
9. Medical Director	0	0	9,300	9,300	0	9,300	0	9,300
10. Nursing & Medical Records	2,346,882	165,302	14,627	2,526,811	0	2,526,811	-14,826	#####
10a. Therapy	0	0	461,075	461,075	0	461,075	0	461,075
11. Activities	222,991	475	1,452	224,918	0	224,918	-113,469	111,449
12. Social Services	72,094	62	0	72,156	0	72,156	0	72,156
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	2,641,967	165,839	486,454	3,294,260	0	3,294,260	-128,295	#####
17. Administrative	0	0	460,100	460,100	0	460,100	-376,731	83,369
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	31,907	31,907	0	31,907	20,014	51,921
20. Fees, Subscriptions & Promotion	0	0	10,420	10,420	0	10,420	-51	10,369
21. Clerical & General Office	80,568	5,502	60,815	146,885	0	146,885	91,247	238,132
22. Employee Benefits & Payroll	0	0	541,972	541,972	0	541,972	51,231	593,203
23. Inservice Training & Education	0	0	1,595	1,595	0	1,595	176	1,771
24. Travel and Seminar	0	0	0	0	0	0	85	85
25. Other Admin. Staff Trans	0	0	11,413	11,413	0	11,413	7,208	18,621
26. Insurance-Prop.Liab.Malpractice	0	0	57,655	57,655	0	57,655	1,015	58,670
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	80,568	5,502	1,175,877	1,261,947	0	1,261,947	-205,806	#####
29. Total General Administrative	3,666,827	613,136	2,479,527	6,759,490	0	6,759,490	-1,008,938	#####
30. Depreciation	0	0	29,937	29,937	0	29,937	114,092	144,029
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	8,275	8,275
32. Interest	0	0	23,784	23,784	0	23,784	145,688	169,472
33. Real Estate	0	0	0	0	0	0	242,099	242,099
34. Rent - Facility & Grounds	0	0	7,429	7,429	0	7,429	-7,429	0
35. Rent - Equipment & Vehicles	0	0	26,334	26,334	0	26,334	1,648	27,982
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	87,484	87,484	0	87,484	504,373	591,857
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	109,335	0	109,335	0	109,335	0	109,335
40. Barber and Beauty Shop	0	0	1,450	1,450	0	1,450	-1,450	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	257,571	257,571	0	257,571	0	257,571
43. Other (specify):*	19,944	1,027	238,027	258,998	0	258,998	-258,998	0
44. Total Special Cost Ce	19,944	110,362	497,048	627,354	0	627,354	-260,448	366,906
45. Grand Total	3,686,771	723,498	3,064,059	7,474,328	0	7,474,328	-765,013	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-214,363	-214,363
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,767,587	1,767,587
4. Supply Inventory	21,685	21,685
5. Short-Term Investments	0	0
6. Prepaid Insurance	51,242	51,242
7. Other Prepaid Expenses	44,393	44,393
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	907	1,314,183
10. Total current assets	1,671,451	2,984,727
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	309,300
14. Buildings, at Historical Cost	0	2,062,592
15. Leasehold Improvements, Historical Cost	99,183	100,737
16. Equipment, at Historical Cost	134,001	326,001
17. Accumulated Depreciation (book methods)	-88,815	-826,657
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	577,000	577,000
23. other (specify):	0	493,664
24. Total Long-Term Assets	721,369	3,042,637
25. Total Assets	2,392,820	6,027,364
CURRENT LIABILITIES		
26. Accounts Payable	1,549,746	1,549,746
27. Officer's Accounts Payable	-231,143	-231,143
28. Accounts Payable-Patients Deposits	109,673	109,673
29. Short-Term Notes Payable	1,165,690	1,165,690
30. Accrued Salaries Payable	132,466	132,466
31. Accrued Taxes Payable	458,554	458,554
32. Accrued Real Estate Taxes	0	454,916
33. Accrued Interest Payable	5,167	5,167
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	8,090	8,090
37. Other Current Liabilities (specify):	37,650	37,650
38. Total Current Liabilities	3,235,893	3,690,809
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	3,000,979
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	146,520	146,520
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	146,520	3,147,499
46.Total Liabilities	3,382,413	6,838,308
47.Total Equity	-989,593	-810,944
48.Total Liabilities and Equity	2,392,820	6,027,364

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,027,908
2. Discounts and Allowances for all Levels	-391,500
Subtotal - Inpatient Care	5,636,408
4. Day Care	0
5. Other Care for Outpatients	222,961
6. Therapy	839,855
7. Oxygen	3,623
Subtotal - Ancillary Revenue	1,066,439
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	32,199
14. Non-Patient Meals	5,494
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	1,750
17. Sale of Drugs	172,773
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	16,022
21. Other Medical Services	39,665
22. Laundry	0
Subtotal - Other Operating Revenue	267,903
24. Contributions	0
25. Interest and Other Investments Income	13
Subtotal - Non-Operating Revenue	13
27. Other Revenue (specify):	113,469
28. Other Revenue (specify):	124,065
Subtotal - Other Revenue	237,534
30. Total Revenue	7,208,297
31. General Services	2,094,338
32. Health Care	3,304,508
33. General Administration	1,073,944
34. Ownership	491,243
35. Special Cost Centers	428,208
35. Provider Participation Fee	253,241
37. Other	0
40. Total Expenses	7,645,482
41. Income Before Income Taxes	-437,185
42. Income Taxes	0
43. Net Income or Loss for the Year	-437,185