FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 (Number) Sullivan (City) 61951 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 1/1/2017 to 12/31/2017 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: 1/1/2017 Ending: 12/31/2017

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	72	Skilled (SNF)	72	26,280	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5	48	Sheltered Care (SC)	48	17,520	5
6		ICF/DD 16 or Less			6
7	170	TOTALS	170	62,050	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,485	8,840	3,592	13,917	8
9	SNF/PED					9
10	ICF	18,250			18,250	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,735	8,840	3,592	32,167	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.84%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] 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 [X] Date 1/1/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 72 and days of care provided 3,404

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Mason Point # 0050294 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	379,489	27,881		407,370		407,370	(133,974)	273,396			1
2	Food Purchase		313,752		313,752		313,752	(115,935)	197,817			2
3	Housekeeping	182,338	60,811		243,149		243,149	(84,167)	158,982			3
4	Laundry	76,583	22,134		98,717		98,717	(102,855)	(4,138)			4
5	Heat and Other Utilities			834,949	834,949		834,949	(315,970)	518,979			5
6	Maintenance	297,398	29,408	49,295	376,101		376,101	(110,384)	265,717			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	935,808	453,986	884,244	2,274,038		2,274,038	(863,285)	1,410,753			8
	B. Health Care and Programs											
9	Medical Director			9,300	9,300		9,300		9,300			9
10	Nursing and Medical Records	2,355,666	169,760	24,176	2,549,602		2,549,602	(33,025)	2,516,577			10
10a	Therapy			412,085	412,085		412,085		412,085			10a
11	Activities	206,187	208	88	206,483		206,483	(105,781)	100,702			11
12	Social Services	75,037			75,037		75,037		75,037			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	2,636,890	169,968	445,649	3,252,507		3,252,507	(138,806)	3,113,701			16
	C. General Administration											
17	Administrative			446,700	446,700		446,700	(360,200)	86,500			17
18	Directors Fees											18
19	Professional Services			55,462	55,462		55,462	17,615	73,077			19
20	Dues, Fees, Subscriptions & Promotions			7,789	7,789		7,789	169	7,958			20
21	Clerical & General Office Expenses	77,632	4,878	36,989	119,499		119,499	77,214	196,713			21
22	Employee Benefits & Payroll Taxes			366,494	366,494		366,494	34,959	401,453			22
23	Inservice Training & Education			(5,734)	(5,734)		(5,734)	216	(5,518)			23
24	Travel and Seminar							107	107			24
25	Other Admin. Staff Transportation			8,695	8,695		8,695	5,175	13,870			25
26	Insurance-Prop.Liab.Malpractice			58,457	58,457		58,457	1,371	59,828			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	77,632	4,878	974,852	1,057,362		1,057,362	(223,374)	833,988			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,650,330	628,832	2,304,745	6,583,907		6,583,907	(1,225,465)	5,358,442			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mason Point #0050294 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			36,794	36,794		36,794	113,004	149,798			30
31	Amortization of Pre-Op. & Org.							7,676	7,676			31
32	Interest			68,058	68,058		68,058	121,154	189,212			32
33	Real Estate Taxes							238,989	238,989			33
34	Rent-Facility & Grounds			587,818	587,818		587,818	(587,818)				34
35	Rent-Equipment & Vehicles			31,065	31,065		31,065	2,194	33,259			35
36	Other (specify):*											36
37	**TOTAL Ownership**			723,735	723,735		723,735	(104,801)	618,934			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		124,320		124,320		124,320		124,320			39
40	Barber and Beauty Shops			767	767		767	(767)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			242,782	242,782		242,782		242,782			42
43	Other (specify):*	66,960	675	348,603	416,238		416,238	(416,238)				43
44	**TOTAL Special Cost Centers**	66,960	124,995	592,152	784,107		784,107	(417,005)	367,102			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,717,290	753,827	3,620,632	8,091,749		8,091,749	(1,747,271)	6,344,478			45

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,984)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,856)	43		5
6	Rented Facility Space	(525)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(11,625)	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(60)	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	(312,130)	43		18
19	Entertainment				19
20	Contributions	(3,000)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,158)	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	(1,129,627)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,483,970)		$	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)	(263,301)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (263,301)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,747,271)		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

Mason Point

ID# 0050294

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	(11,647)	43	1
2	X-Rays-Part A	(4,318)	43	2
3	Offset Privately Paid Electricity	(26,955)	5	3
4	Offset Transportation Revenue	(105,781)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(278)	21	5
6	Offset Miscellaneous Nursing Supplies Revenue	(33,125)	10	6
7	Offset Miscellaneous Laundry Supplies Revenue	(68,640)	4	7
8	Disallowed Special Events	(679)	43	8
9	Pet Expense	(1,282)	43	9
10	Offset Independent Living Depreciation	(24,292)	30	10
11	Offset Independent Living Dietary	(141,195)	1	11
12	Offset Independent Living Food	(108,747)	2	12
13	Offset Independent Living Housekeeping	(84,276)	3	13
14	Offset Independent Living Laundry	(34,215)	4	14
15	Offset Independent Living Utilities	(289,395)	5	15
16	Offset Independent Living Maintenance	(113,271)	6	16
17	Offset Privately Paid Telephone	(229)	21	17
18	Disallow Marketing Expense	(66,960)	43	18
19	Offset Barber and Beauty Revenue	(767)	40	19
20	Resident Flowers	(148)	43	20
21	Offset Escrow Refund	(12,192)	32	21
22	Offset Guest Tray Service	(1,235)	2	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**	(1,129,627)		49

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 7,221	$ 7,221	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	31	31	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	109	109	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	380	380	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,412	3,412	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%	100	100	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	446,700	Petersen Health Care Management, Inc.	100.00%	86,500	(360,200)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	22,615	22,615	12
13	V								13
14	Total			$ 446,700			$ 120,368	$ * (326,332)	14

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 169	$ 169	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	77,721	77,721	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	34,959	34,959	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	216	216	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	107	107	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	5,175	5,175	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,371	1,371	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	18,509	18,509	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	167	167	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	602	602	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	415	415	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	2,194	2,194	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			$			$ 141,605	$ * 141,605	39

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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. [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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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%	130,412	130,412	18
19	V	31	Amortization		Petersen VII, LLC	100.00%	7,509	7,509	19
20	V	32	Interest		Petersen VII, LLC	100.00%	132,749	132,749	20
21	V	33	Real Estate Taxes		Petersen VII, LLC	100.00%	238,574	238,574	21
22	V	34	Rent-Income and Grounds	587,818	Petersen VII, LLC	100.00%		(587,818)	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			$ 587,818			$ 509,244	$ * (78,574)	39

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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, L	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 Entert	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 Systen	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 LL	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care M	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 Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	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: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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 [X] NO [ ]

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

Name of Related Organization: Petersen Health Care Management, 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,451,714	75	$ 325,901	$ 376,129	32,167	$ 7,221	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	32,167	31	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	32,167	109	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	32,167	380	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	32,167	3,412	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	32,167	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	32,167	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	32,167	100	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	32,167	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	32,167	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	32,167	86,500	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	32,167	22,615	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	32,167	169	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	32,167	77,721	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	32,167	34,959	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	32,167	216	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	32,167	107	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	32,167	5,175	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	32,167	1,371	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	32,167	18,509	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	32,167	167	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	32,167	602	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	32,167	415	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	32,167	2,194	24
25	TOTALS					$ 12,790,903	$ 11,700,485		$ 261,973	25

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bank Leumi		X	Mortgage	Varies	5/20/2016	$ 3,300,000	$ 2,879,391	5/19/2041	Varies	$ 132,749	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Working Capital	Varies	7/28/2017	1,200,000	1,095,690	7/28/2018	Varies	68,058	6
7												7
8												8
9	TOTAL Facility Related						$ 4,500,000	$ 3,975,081			$ 200,807	9
	B. Non-Facility Related*											
10								Interest Income Offset			(5)	10
11								Home Office Allocation-PHCM			602	11
12								Escrow Refund			(12,192)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11,595)	14
15	TOTALS (line 9+line14)						$ 4,500,000	$ 3,975,081			$ 189,212	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 & ID Number Mason Point # 0050294 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	285,199	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.)	$	133,912	2
3. Under or (over) accrual (line 2 minus line 1).	$	(151,287)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	372,691	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.		17,170	
Home Office Allocation		415	
TOTAL REFUND $ 17,170 **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.	$	238,989	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	139,183	8
	2013	204,474	9
	2014	206,992	10
	2015	241,632	11
	2016	133,912	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-09-05-000-106	Long-Term Nursing Facility	$ 133,912.14	$ 133,912.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 133,912.14	$ 133,912.14

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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? [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. [X] (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: 7,676 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:

A. Land.

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2009	1950	$ 2,045,700	$	25	$ 81,828	$ 34,053	$ 695,538	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			2,936	9
10	Automatic Door Opener/Closer			2010	8,185		15	546	546	4,095	10
11	Roof Repairs			2011	9,265		7			9,265	11
12	Elevator Repair			2012	4,817		7	688	688	3,784	12
13	Water Tower Repair			2013	2,725		7	390	390	1,755	13
14	Door Restrictors			2014	10,346		7	1,478	1,478	5,173	14
15	Door Restrictors			2015	10,346		7	1,478	1,478	3,695	15
16	Generator Repair			2015	9,464		7	1,352	1,352	3,380	16
17	Elevator Repair			2015	8,380		7	1,198	1,198	2,995	17
18	Elevator Repair			2015	2,810		7	402	402	1,005	18
19	Wall Painting-Auditorium, Hallways, Back Rooms			2016	16,977		15	1,132	1,132	1,698	19
20	Tiling Replacement-Hallways, Common Area			2016	10,010		10	1,002	1,002	1,503	20
21	Water Heater			2016	2,920		7	418	418	627	21
22	Flooring for Mason Circle 1			2017	2,713		7	194	194	194	22
23	Air Circulator			2017	2,783		7	199	199	199	23
24	Elevator Repair			2017	2,601		7	186	186	186	24
25	Concrete Raising at Sidewalks			2017	2,850		7	204	204	204	25
26	Elevator Repair			2017	3,257		7	233	233	233	26
27	Boiler			2017	14,952		15	498	498	498	27
28											28
29											29
30											30
31	Building Booked					106,120			(106,120)		31
32	Building Improvement Booked					12,469			(12,469)		32
33											33
34	2017-Home Office Allocation-Building Improvements				14,714			353	353		34
35	2017-Home Office Allocation-Land Improvements				1,354			88	88		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: 1/1/2017 Ending: 12/31/2017

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)		$ 2,190,105	$ 118,589		$ 93,867	$ (72,497)	$ 738,963	70

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 321,002	$ 18,579	$ 33,617	$ 15,038	5-10 yrs.	$ 214,237	71
72	Current Year Purchases	43,496	3,037	3,107	70	7 yrs.	3,107	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			18,068	18,068			74
75	TOTALS	$ 364,498	$ 21,616	$ 54,792	$ 33,176		$ 217,344	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)	5 yrs.	$ 5,000	76
77	Facility	2012 Ford E-150 Van	2017	11,393	1,709	1,139	(570)	5 yrs.	1,139	77
78										78
79										79
80	TOTALS			$ 16,393	$ 2,709	$ 1,139	$ (1,070)		$ 6,139	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)	$ 2,880,296	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 142,914	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 149,798	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,384	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 962,446	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	$ 306,628	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 776,000	$ 24,292	$ 306,628	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.

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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: _____ *

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 33,259 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

* 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 **1/1/2017**
Period End **12/31/2017**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 25,085
Dishwasher	701
Copier	5,279
Home Office Allocation	2,194
	33,259

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Mason Point STATE OF ILLINOIS # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	10,122	$ 151,830	$	10,122	$ 151,830	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		5,188	77,813		5,188	77,813	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		12,163	182,442		12,163	182,442	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				124,320		124,320	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			$	27,473	$ 412,085	$ 124,320	27,473	$ 536,405	14

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

STATE OF ILLINOIS

Facility Name & ID Number Mason Point # 0050294 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (300,607)	$ (300,607)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 116,338)	1,743,357	1,743,357	3
4	Supply Inventory (priced at Cost)	21,685	21,685	4
5	Short-Term Investments			5
6	Prepaid Insurance	39,855	39,855	6
7	Other Prepaid Expenses	332,075	332,075	7
8	Accounts Receivable (owners or related parties)	200,000	200,000	8
9	Other(specify): Employee Education Loans	782	782	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,037,147	$ 2,037,147	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		2,060,414	14
15	Leasehold Improvements, at Historical Cost	128,337	129,691	15
16	Equipment, at Historical Cost	188,891	380,891	16
17	Accumulated Depreciation (book methods)	(125,608)	(962,446)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		97,555	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill	577,000	577,000	22
23	Other(specify): Independent Living Facility		469,372	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 768,620	$ 3,061,777	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,805,767	$ 5,098,924	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,746,398	$ 1,746,398	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	103,616	103,616	28
29	Short-Term Notes Payable	1,095,690	1,095,690	29
30	Accrued Salaries Payable	117,462	117,462	30
31	Accrued Taxes Payable (excluding real estate taxes)	139,125	139,125	31
32	Accrued Real Estate Taxes(Sch.IX-B)		372,691	32
33	Accrued Interest Payable	6,390	6,390	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	2,106	2,106	36
37	Accrued Management Fees	72,547	72,547	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,283,334	$ 3,656,025	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,879,391	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,738,679	593,498	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,738,679	$ 3,472,889	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,022,013	$ 7,128,914	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,216,246)	$ (2,029,990)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,805,767	$ 5,098,924	48

***(See instructions.)**

Facility Name & ID Number Mason Point **#** 0050294 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (989,593)	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Report Was Filed**	14,152	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (975,441)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,240,805)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,240,805)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,216,246)	24 *

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,671,874	1
2	Discounts and Allowances for all Levels	(392,374)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,279,500	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	241,811	5
6	Therapy	783,305	6
7	Oxygen	4,605	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,029,721	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	22,687	13
14	Non-Patient Meals	7,219	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	525	16
17	Sale of Drugs	196,135	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,182	20
21	Other Medical Services	52,770	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 294,518	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	105,781	28
28a	Miscellaneous Revenue	141,419	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 247,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,850,944	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,274,038	31
32	Health Care	3,252,507	32
33	General Administration	1,057,362	33
	B. Capital Expense		
34	Ownership	723,735	34
	C. Ancillary Expense		
35	Special Cost Centers	541,325	35
36	Provider Participation Fee	242,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,091,749	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,240,805)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,240,805)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,782,385	44
45	Private Pay - Net Inpatient Revenue	1,791,954	45
46	Medicare - Net Inpatient Revenue	695,428	46
47	Other-(specify) Insurance Net Inpatient Revenue	9,733	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,279,500	49

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

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

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

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,793	2,824	$ 81,903	$ 29.00	1
2	Assistant Director of Nursing	2,080	2,080	60,047	28.87	2
3	Registered Nurses	15,870	16,815	429,269	25.53	3
4	Licensed Practical Nurses	21,597	22,677	464,832	20.50	4
5	CNAs & Orderlies	84,696	90,838	1,174,329	12.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,629	8,522	91,839	10.78	10
11	Social Service Workers	5,004	5,199	75,037	14.43	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	32,451	15.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	33,753	34,823	347,038	9.97	15
16	Dishwashers					16
17	Maintenance Workers	13,130	13,539	297,398	21.97	17
18	Housekeepers	17,968	18,440	182,338	9.89	18
19	Laundry	8,597	8,913	76,583	8.59	19
20	Administrator	2,080	2,080	86,500	41.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,082	4,244	77,632	18.29	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	2,000	2,047	21,767	10.63	31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	14,293	15,005	304,827	20.32	33
34	TOTAL (lines 1 - 33)	237,652	250,126	$ 3,803,790 *	$ 15.21	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		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	3	125	L10A, C3	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)	3	$ 15,425		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	232	$ 6,679	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	232	$ 6,679		53

Mason Point
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Period Beginning **1/1/2017**
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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		3,873	3,951	112,002	28.35
Restorative Nurse		428	428	11,517	26.91
Transportation		5,852	6,326	114,348	18.08
Marketing		4,140	4,300	66,960	15.57
	TOTAL	14,293	15,005	304,827	

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darin Wall	Administrator	0	$ 86,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 86,500

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 446,700
TOTAL (agree to Schedule V, line 17, col. 3)	$ 446,700
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Computer Services	$ 4,567
SB2	Refund of Legal Fees	(310)
Alix Partners	Consulting Fees	38,159
Ginoli and Company	Accounting Services	4,245
Honkamp Krueger & Co.	Accounting Services	1,298
Peoria County Recorder	Legal Fees	153
Prairie State Bank & Trust	Legal Fees	20
Allscripts	Data Services	888
Shawnee Communications	Computer Services	1,300
Coles County Circuit Clerk	Legal Fees	142
Christoper Ryan	Settlement	5,000
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 55,462

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 59,586
Unemployment Compensation Insurance	32,300
FICA Taxes	271,912
Employee Health Insurance	(1,666)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,536
Employee Retirement	1,826
Home Office Allocation	34,959
TOTAL (agree to Schedule V, line 22, col.8)	$ 401,453

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 273)	1,836
Miscellaneous Licenses & Permits	2,110
Miscellaneous Dues & Subscriptions	1,853
Home Office Allocation	169
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,958

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	107
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 107

**See instructions.

Mason Point
0050294
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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		55,462
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	258
Arnstein & Lehr	Legal	1737
SB2	Legal	1092
Miscellaneous	Legal	20
Miller Hall and Triggs	Legal	276
Smith Amundsen	Legal	107
Healthcare Resources International	Legal	192
Hunziker Law	Legal	1
Lexis Nexis	Legal	11
Baker Tilly Virchow Krause	Legal	969
CliftonLarsonAllen	Accounting	3103
Ginoli & Co.	Accounting	609
Baker Tilly Virchow Krause	Accounting	194
Miscellaneous	Computer Services	146
Change Healthcare	Computer Services	12
360 Networks	Computer Services	59
Matrix Care	Computer Services	5412
Stratus Networks	Computer Services	646
Kemper Technology	Computer Services	367
AT&T	Computer Services	9
Ability Network	Computer Services	399
CIAN	Computer Services	450
Comcast	Computer Services	25
CCH	Computer Services	22
Charter Communications	Computer Services	45
Allscripts	Computer Services	401
ATS	Computer Services	412
Citrix Systems	Computer Services	38
Optimizer	Other Prof Fees	72
Ankura	Other Prof Fees	1165
David Budde	Other Prof Fees	54
Sargent Consulting	Other Prof Fees	3239
Alix Partners	Other Prof Fees	787
Demonica Kemper	Other Prof Fees	48
Brad Barkley	Other Prof Fees	191
MPAC Healthcare	Other Prof Fees	29
Higgs Appraisal	Other Prof Fees	13
Alan Litwiller	Other Prof Fees	5
Total (agree to Schedule V, line 19, column 8)		78,077

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-**

(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? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,354** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **242,782**
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. $ **5,984**

(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. $ **105,781**
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **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? **Yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

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

Independent Living Offset

Schedule 23A

Census Days Summary:	**Days**	**%**
Independent Living	18,530	34.66%
Nursing Home	32,167	60.17%
	53,462	100.00%

Expense Offset:	**Total Amount**	**Ind. Liv %**	**Ind. Liv Offset**	**Basis For Allocation**	**Line**
Dietary	407,370	34.66%	141,195	Census	1
Food	313,752	34.66%	108,747	Census	2
Housekeeping	243,149	34.66%	84,276	Census	3
Laundry	98,717	34.66%	34,215	Census	4
Utilities	834,949	34.66%	289,394	Census	5
Maintenance	326,806	34.66%	113,271	Census	6
Depreciation (Building)	24,292	100.00%	24,292	Beds	30
Total	2,249,035		795,391		

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.