		FOR BHF USE					

LL1

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 1/1/2018 to 12/31/2018 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: 1/1/2018 Ending: 12/31/2018

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	838	8,563	4,344	13,745	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	19,088	8,563	4,344	31,995	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.56%

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 3,781

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: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	359,213	29,316		388,529		388,529	(130,462)	258,067			1
2	Food Purchase		328,670		328,670		328,670	(125,885)	202,785			2
3	Housekeeping	173,317	51,657		224,974		224,974	(79,919)	145,055			3
4	Laundry	85,859	19,350		105,209		105,209	(106,072)	(863)			4
5	Heat and Other Utilities			903,910	903,910		903,910	(352,149)	551,761			5
6	Maintenance	297,119	38,535	53,420	389,074		389,074	(136,530)	252,544			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	915,508	467,528	957,330	2,340,366		2,340,366	(931,017)	1,409,349			8
	B. Health Care and Programs											
9	Medical Director			19,780	19,780		19,780		19,780			9
10	Nursing and Medical Records	2,399,664	139,093	(40,079)	2,498,678		2,498,678	(21,176)	2,477,502			10
10a	Therapy		(250)	573,017	572,767		572,767		572,767			10a
11	Activities	184,539	650	(779)	184,410		184,410	(123,350)	61,060			11
12	Social Services	88,768			88,768		88,768		88,768			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	2,672,971	139,493	551,939	3,364,403		3,364,403	(144,526)	3,219,877			16
	C. General Administration											
17	Administrative	677		459,300	459,977		459,977	(371,375)	88,602			17
18	Directors Fees											18
19	Professional Services			50,292	50,292		50,292	23,520	73,812			19
20	Dues, Fees, Subscriptions & Promotions			6,957	6,957		6,957	5,764	12,721			20
21	Clerical & General Office Expenses	86,783	4,581	32,791	124,155		124,155	79,116	203,271			21
22	Employee Benefits & Payroll Taxes			350,863	350,863		350,863	33,488	384,351			22
23	Inservice Training & Education			905	905		905	195	1,100			23
24	Travel and Seminar							4	4			24
25	Other Admin. Staff Transportation			12,688	12,688		12,688	5,915	18,603			25
26	Insurance-Prop.Liab.Malpractice			61,904	61,904		61,904	1,483	63,387			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	87,460	4,581	975,700	1,067,741		1,067,741	(221,890)	845,851			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,675,939	611,602	2,484,969	6,772,510		6,772,510	(1,297,433)	5,475,077			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: 1/1/2018 Ending: 12/31/2018

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			49,294	49,294		49,294	114,017	163,311			30
31	Amortization of Pre-Op. & Org.							7,846	7,846			31
32	Interest			35,096	35,096		35,096	292,807	327,903			32
33	Real Estate Taxes							128,601	128,601			33
34	Rent-Facility & Grounds			421,798	421,798		421,798	(421,798)				34
35	Rent-Equipment & Vehicles			22,018	22,018		22,018	1,708	23,726			35
36	Other (specify):*											36
37	**TOTAL Ownership**			528,206	528,206		528,206	123,181	651,387			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		143,355		143,355		143,355		143,355			39
40	Barber and Beauty Shops			818	818		818	(818)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			234,109	234,109		234,109		234,109			42
43	Other (specify):* **Miscellaneous**	69,156	1,202	275,030	345,388		345,388	(345,388)				43
44	**TOTAL Special Cost Centers**	69,156	144,557	509,957	723,670		723,670	(346,206)	377,464			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,745,095	756,159	3,523,132	8,024,386		8,024,386	(1,520,458)	6,503,928			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: 1/1/2018 Ending: 12/31/2018

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	(8,767)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,892)	43		5
6	Rented Facility Space	(1,150)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,822)	30		9
10	Interest and Other Investment Income	267	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(386)	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	(247,042)	43		18
19	Entertainment				19
20	Contributions	(1,250)	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	(2,442)	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	(1,199,988)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,484,472)		$	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)	(35,986)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (35,986)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,520,458)		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: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	(7,610)	43	1
2	X-Rays-Part A	(3,284)	43	2
3	Offset Privately Paid Electricity	(30,948)	5	3
4	Offset Transportation Revenue	(123,350)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(204)	21	5
6	Offset Miscellaneous Nursing Supplies Revenue	(26,553)	10	6
7	Offset Miscellaneous Laundry Supplies Revenue	(68,640)	4	7
8	Disallowed Special Events	(797)	43	8
9	Pet Expense	(492)	43	9
10	Offset Independent Living Depreciation	(24,292)	30	10
11	Offset Independent Living Dietary	(138,233)	1	11
12	Offset Independent Living Food	(116,936)	2	12
13	Offset Independent Living Housekeeping	(80,042)	3	13
14	Offset Independent Living Laundry	(37,432)	4	14
15	Offset Independent Living Utilities	(321,598)	5	15
16	Offset Independent Living Maintenance	(138,427)	6	16
17	Offset Privately Paid Telephone	(414)	21	17
18	Disallow Marketing Expense	(69,156)	43	18
19	Offset Barber and Beauty Revenue	(818)	40	19
20	Resident Flowers	(37)	43	20
21	Offset Escrow Refund	(10,470)	32	21
22	Offset Guest Tray Service	(255)	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**	(1,199,988)		49

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. [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)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 7,771	$ 7,771	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	73	73	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	123	123	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	397	397	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,047	3,047	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%	5,377	5,377	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	459,300	Petersen Health Care Management, Inc.	100.00%	87,925	(371,375)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	23,520	23,520	12
13	V								13
14	Total			$ 459,300			$ 128,233	$ * (331,067)	14

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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%	$ 5,764	$ 5,764	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	79,734	79,734	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	33,488	33,488	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	195	195	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	4	4	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	5,915	5,915	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,483	1,483	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	18,858	18,858	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	171	171	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	4,959	4,959	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	587	587	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,708	1,708	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			$			$ 152,866	$ * 152,866	39

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	30	Depreciation		Petersen VII, LLC	100.00%	130,273	$ 130,273	15
16	V	31	Amortization		Petersen VII, LLC	100.00%	7,675	7,675	16
17	V	32	Interest		Petersen VII, LLC	100.00%	298,051	298,051	17
18	V	33	Real Estate Taxes		Petersen VII, LLC	100.00%	128,014	128,014	18
19	V	34	Rent-Income and Grounds	421,798	Petersen VII, LLC	100.00%		(421,798)	19
20	V								20
21	V								21
22	V								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			$ 421,798			$ 564,013	$ * 142,215	39

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 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 Syster	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 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 Quali	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: 1/1/2018 Ending: 12/31/2018

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 Bloomington Rehabilitation & Health Care Center # 0047415 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 Bloomington Rehabilitation & Health Care Center # 0047415 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: 1/1/2018 Ending: 12/31/2018

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: 1/1/2018 Ending: 2/31/2018

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	1,411,762	75	$ 342,871	$ 393,211	31,995	$ 7,771	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	31,995	73	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	31,995	123	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	31,995	397	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	31,995	3,047	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	31,995	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	31,995	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	31,995	5,377	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	31,995	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	31,995	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	31,995	87,925	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	31,995	23,520	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	31,995	5,764	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	31,995	79,734	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	31,995	33,488	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	31,995	195	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	31,995	4	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	31,995	5,915	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	31,995	1,483	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	832,087	0	31,995	18,858	20
21	30	Depreciation	Resident Days	1,411,762	75	7,528	0	31,995	171	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	31,995	4,959	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	31,995	587	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	31,995	1,708	24
25	TOTALS					$ 13,464,326	$ 11,422,040		$ 281,099	25

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 2,800,397	5/19/2041	Varies	$ 298,051	1
2	Southern Bus & Mobility		X	Van	$590.88	5/1/18	13,729	9,112	4/30/23	Varies	439	2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Working Capital	Varies	7/28/2017	1,200,000	Paid	7/28/2018	Varies	34,657	6
7												7
8												8
9	TOTAL Facility Related				$590.88		$ 4,513,729	$ 2,809,509			$ 333,147	9
	B. Non-Facility Related*											
10								Interest Income Offset			267	10
11								Home Office Allocation-PHCM			4,959	11
12								Escrow Refund			(10,470)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,244)	14
15	TOTALS (line 9+line14)						$ 4,513,729	$ 2,809,509			$ 327,903	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: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 372,691	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.)		$ 236,791	2
3. Under or (over) accrual (line 2 minus line 1).		$ (135,900)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 263,914	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. **Home Office Allocation** 587 **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 128,601	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	204,474	8
	2014	206,992	9
	2015	241,632	10
	2016	133,912	11
	2017	130,006	12

Accrual based on prior year tax bill.
$106,785 paid on 2017 bill

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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	$ 130,005.86	$ 130,005.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 130,005.86	$ 130,005.86

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly

used for nursing home services? _____ YES _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 1/1/2018 Ending: 12/31/2018

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: 7,846
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: 1/1/2018 Ending: 12/31/2018

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	$ 81,828	$ 777,366	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	4,641	10
11	Roof Repairs			2011	9,265		7			9,265	11
12	Elevator Repair			2012	4,817		7	688	688	4,472	12
13	Water Tower Repair			2013	2,725		7	390	390	2,145	13
14	Door Restrictors			2014	10,346		7	1,478	1,478	6,651	14
15	Door Restrictors			2015	10,346		7	1,478	1,478	5,173	15
16	Generator Repair			2015	9,464		7	1,352	1,352	4,732	16
17	Elevator Repair			2015	8,380		7	1,198	1,198	4,193	17
18	Elevator Repair			2015	2,810		7	402	402	1,407	18
19	Wall Painting-Auditorium, Hallways, Back Rooms			2016	16,977		15	1,132	1,132	2,830	19
20	Tiling Replacement-Hallways, Common Area			2016	10,010		10	1,002	1,002	2,505	20
21	Water Heater			2016	2,920		7	418	418	1,045	21
22	Flooring for Mason Circle 1			2017	2,713		7	388	388	582	22
23	Air Circulator			2017	2,783		7	398	398	597	23
24	Elevator Repair			2017	2,601		7	372	372	558	24
25	Concrete Raising at Sidewalks			2017	2,850		7	408	408	612	25
26	Elevator Repair			2017	3,257		7	466	466	699	26
27	Boiler			2017	14,952		15	996	996	1,494	27
28	Elevator Repair			2018	5,628		7	402	402	402	28
29	Alarm System Repair			2018	10,847		7	775	775	775	29
30	HVAC Repair			2018	2,640		7	189	189	189	30
31	Generator Repair			2018	8,928		7	638	638	638	31
32	Air Conditioner			2018	8,500		15	567	567	567	32
33	Carpet Replacement			2018	3,000		10	150	150	150	33
34	Boiler Repair			2018	19,033		7	1,360	1,360	1,360	34
35	Water Heater			2018	15,062		7	1,076	1,076	1,076	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: 1/1/2018 Ending: 12/31/2018

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	Building Booked			106,120			(106,120)		63
64	Building Improvement Booked			19,034			(19,034)		64
65									65
66	2018-Home Office Allocation-Building Improvements		15,049			361	361		66
67	2018-Home Office Allocation-Land Improvements		1,510			96	96		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,264,234	$ 125,154		$ 100,554	$ (24,600)	$ 839,060	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: 1/1/2018 Ending: 12/31/2018

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	$ 364,498	$ 23,970	$ 39,831	$ 15,861	5-10 yrs.	$ 257,175	71
72	Current Year Purchases	12,002	789	858	69	7 yrs.	858	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			18,401	18,401			74
75	TOTALS	$ 376,500	$ 24,759	$ 59,090	$ 34,331		$ 258,033	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	2,279	2,278	(570)	5 yrs.	3,417	77
78	Facility	2015 Ford E-150 Van	2018	13,886	2,083	1,389	(694)	5 yrs.	1,389	78
79										79
80	TOTALS			$ 30,279	$ 5,362	$ 3,667	$ (1,764)		$ 9,806	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)	$	2,980,313	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	155,275	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	163,311	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	7,967	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,106,899	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	$ 330,920	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 776,000	$ 24,292	$ 330,920	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: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 23,726 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 1/1/2018
Period End 12/31/2018

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	10,568
Dishwasher		701
Copier		10,749
Home Office Allocation		1,708
		23,726

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.

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	$	15,900	$ 238,493	$	15,900	$ 238,493	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		5,394	80,916		5,394	80,916	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		16,907	253,608	(250)	16,907	253,358	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				143,355		143,355	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			$	38,201	$ 573,017	$ 143,105	38,201	$ 716,122	14

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (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	$ (282,455)	$ (282,455)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 106,149)	1,612,495	1,612,495	3
4	Supply Inventory (priced at Cost)	21,685	21,685	4
5	Short-Term Investments			5
6	Prepaid Insurance	36,325	36,325	6
7	Other Prepaid Expenses	43,523	43,523	7
8	Accounts Receivable (owners or related parties)	180,000	180,000	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,611,573	$ 1,611,573	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		2,060,749	14
15	Leasehold Improvements, at Historical Cost	201,975	203,485	15
16	Equipment, at Historical Cost	214,779	406,779	16
17	Accumulated Depreciation (book methods)	(174,901)	(1,106,899)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		79,545	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		445,080	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 818,853	$ 2,975,039	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,430,426	$ 4,586,612	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,861,222	$ 1,861,222	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	106,216	106,216	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,314	120,314	30
31	Accrued Taxes Payable (excluding real estate taxes)	827,578	827,578	31
32	Accrued Real Estate Taxes(Sch.IX-B)		263,914	32
33	Accrued Interest Payable			33
34	Deferred Compensation		169,023	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	4,095	4,095	36
37	Accrued Management Fees	148,708	148,708	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,068,133	$ 3,501,070	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,112	9,112	39
40	Mortgage Payable		2,800,397	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	2,161,818	847,614	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,170,930	$ 3,657,123	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,239,063	$ 7,158,193	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,808,637)	$ (2,571,581)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,430,426	$ 4,586,612	48

*(See instructions.)

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,216,246)	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Reports Were Filed**	346,028	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,870,218)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(918,419)	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	(20,000)	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)**	$ (938,419)	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)**	$ (2,808,637)	24 *

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

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 5,674,466	1
2	Discounts and Allowances for all Levels	(536,192)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,138,274	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	231,715	5
6	Therapy	1,150,042	6
7	Oxygen	4,081	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,385,838	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	17,922	13
14	Non-Patient Meals	9,022	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,150	16
17	Sale of Drugs	224,772	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	21,169	20
21	Other Medical Services	47,508	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 321,543	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(267)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (267)	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Transportation Revenue	123,350	28
28a	Miscellaneous Revenue	137,229	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 260,579	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,105,967	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,340,366	31
32	Health Care	3,364,403	32
33	General Administration	1,067,741	33
	B. Capital Expense		
34	Ownership	528,206	34
	C. Ancillary Expense		
35	Special Cost Centers	489,561	35
36	Provider Participation Fee	234,109	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,024,386	40
41	**Income before Income Taxes (line 30 minus line 40)****	(918,419)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (918,419)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,533,287	44
45	Private Pay - Net Inpatient Revenue	1,822,197	45
46	Medicare - Net Inpatient Revenue	697,071	46
47	Other-(specify) Insurance Net Inpatient Revenue	85,719	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,138,274	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: 1/1/2018 Ending: 12/31/2018

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	2,851	2,878	$ 84,899	$ 29.50	1
2	Assistant Director of Nursing	2,101	2,164	60,450	27.93	2
3	Registered Nurses	11,482	14,824	398,718	26.90	3
4	Licensed Practical Nurses	21,099	21,049	446,460	21.21	4
5	CNAs & Orderlies	90,383	93,698	1,252,093	13.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,040	1,040	18,302	17.60	8
9	Activity Director					9
10	Activity Assistants	5,718	5,931	81,803	13.79	10
11	Social Service Workers	5,678	6,051	88,768	14.67	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,040	33,155	16.25	13
14	Head Cook					14
15	Cook Helpers/Assistants	29,634	30,453	326,058	10.71	15
16	Dishwashers					16
17	Maintenance Workers	13,525	14,185	297,119	20.95	17
18	Housekeepers	17,147	17,307	173,317	10.01	18
19	Laundry	6,535	7,057	85,859	12.17	19
20	Administrator	2,080	2,080	88,602	42.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,033	2,105	45,564	21.65	23
24	Clerical	4,160	4,160	41,219	9.91	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	1,951	2,110	27,754	13.15	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	4,229	4,229	282,880	66.89	33
34	TOTAL (lines 1 - 33)	223,686	233,361	$ 3,833,020 *	$ 16.43	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	19,780	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)		$ 25,780		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,283	$ 44,748	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,283	$ 44,748		53

Mason Point
0050294
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		4,133	4,271	110,988	25.99
Transportation		6,276	6,643	102,736	15.47
Marketing		4,229	4,229	69,156	16.35
	TOTAL	14,638	15,143	282,880	

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darin Wall	Administrator	0	$ 88,602
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,602

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 459,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 459,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Computer Services	$ 859
American Healthtech	Reversal of 2017 Fees	(5,073)
Loan Recovery Corp.	Debt Recovery Services	27,000
DFH Capital	Debt Recovery Services	12,321
Ginoli and Company	Accounting Services	3,575
Peoria County Recorder	Legal Fees	138
IL Secretary of State	Legal Fees	95
Allscripts	Data Services	444
Shawnee Communications	Computer Services	1,632
Coles County Circuit Clerk	Reversal of Legal Fees	(284)
DFH Capital	Consulting Fees	9,257
Heart Technologies	Computer Services	328
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 50,292

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,934
Unemployment Compensation Insurance	25,084
FICA Taxes	275,441
Employee Health Insurance	(216)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	3,618
Home Office Allocation	33,488
Employee Retirement	2,002
TOTAL (agree to Schedule V, line 22, col.8)	$ 384,351

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	$ 3,990
Advertising: Employee Recruitment	80
Health Care Worker Background Check	
(Indicate # of checks performed 46)	1,380
Patient Background Checks	168
Miscellaneous Licenses & Permits	119
Miscellaneous Dues & Subscriptions	1,220
Home Office Allocation	5,764
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,721

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	4
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4

**See instructions.

Mason Point
0050294
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		50,292
Home Office Allocation		
Duane Morris	Legal	3215
Sedgwick CMS	Legal	285
SB2	Legal	794
Miscellaneous	Legal	236
Christoper P. Ryan	Legal	251
Saul Ewing Arnstein & Lehr	Legal	1126
Healthcare Resources International	Legal	169
Winston & Strawn	Legal	2710
Lexis Nexis	Legal	12
Pretzel & Stouffer	Legal	40
CliftonLarsonAllen	Accounting	1644
Ginoli & Co.	Accounting	583
Duane Morris	Accounting	96
Getzler Henrich & Associates	Accounting	1263
Kemper Consulting	Accounting	96
Baker Tilly Virchow Krause	Accounting	665
Miscellaneous	Computer Services	172
Change Healthcare	Computer Services	6
TR Professional	Computer Services	16
Matrix Care	Computer Services	1847
Ability Network	Computer Services	2924
Stratus Networks	Computer Services	715
Kemper Technology	Computer Services	821
AT&T	Computer Services	10
Ungerboeck Software	Computer Services	591
CIAN	Computer Services	257
Comcast	Computer Services	64

CCH	Computer Services	24
Charter Communications	Computer Services	43
Allscripts	Computer Services	831
ATS	Computer Services	386
Citrix Systems	Computer Services	135
Optimizer	Other Prof Fees	75
Sedgwick CLMS	Other Prof Fees	260
David Budde	Other Prof Fees	74
Sargent Consulting	Other Prof Fees	204
Alix Partners	Other Prof Fees	775
Getzler Henrich & Associates	Other Prof Fees	105
Total (agree to Schedule V, line 19, column 8)		73,812

Mason Point
0050294
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 21A

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PMC & PHCM			
Duane Morris	Legal		3215
Sedgwick CMS	Legal		285
SB2	Legal		794
Miscellaneous	Legal		236
Christoper P. Ryan	Legal		251
Saul Ewing Arnstein & Lehr	Legal		1126
Healthcare Resources International	Legal		169
Winston & Strawn	Legal		2710
Lexis Nexis	Legal		12
Pretzel & Stouffer	Legal		40
Direct Facility Invoices			
Loan Recovery Corp.-Recovery of Debts		3/8/2018	27,000
DFH Capital-Debt Recovery		4/3/2018	2,531
DFH Capital-Debt Recovery		6/27/2018	4,568
DFH Capital-Debt Recovery		11/16/2018	4,076
DFH Capital-Debt Recovery		12/19/2018	1,145
Total Legal Fees (agree to Schedule V, line 19, column 8)			48,159

Effingham Rehabilitation & Health Care Center
0054387
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 21C

25. Administrative and Staff Transportation

Gas	$	2,248
Auto Repairs		8,271
Mileage-Travel		2,169
Home Office Allocation		5,915
		18,603

Facility Name & ID Number Mason Point # 0050294 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. $ **45,285** 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. $ **234,109**
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. $ **8,767**

(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. $ **123,350**
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. $ ____

(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? See page 39 of the instructions for details. **Yes**
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	19,021	35.58%
Nursing Home	31,995	59.85%
	53,462	100.00%

Expense Offset:	**Total Amount**	**Ind. Liv %**	**Ind. Liv Offset**	**Basis For Allocation**	**Line**
Dietary	388,529	35.58%	138,233	Census	1
Food	328,670	35.58%	116,936	Census	2
Housekeeping	224,974	35.58%	80,042	Census	3
Laundry	105,209	35.58%	37,432	Census	4
Utilities	903,910	35.58%	321,598	Census	5
Maintenance	389,074	35.58%	138,427	Census	6
Depreciation (Building)	24,292	100.00%	24,292	Beds	30
Total	2,364,658		856,960		

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.