



Facility Name & ID Number Mason Point

# 0050294 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	13,383	3,732	3,217	20,332	8	
9	SNF/PED					9	
10	ICF		12,319		12,319	10	
11	ICF/DD					11	
12	SC		4,373		4,373	12	
13	DD 16 OR LESS					13	
14	TOTALS	13,383	20,424	3,217	37,024	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.67%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 1/1/2009

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1/1/2009 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 72 and days of care provided 2,903

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number **Mason Point** # **0050294** Report Period Beginning: **1/1/2009** Ending: **12/31/2009**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	383,186	24,382		407,568		407,568	(106,992)	300,576		1
2	Food Purchase		247,038		247,038		247,038	(71,240)	175,798		2
3	Housekeeping	145,092	33,123		178,215		178,215	(49,554)	128,661		3
4	Laundry	90,083	28,329		118,412		118,412	(32,966)	85,446		4
5	Heat and Other Utilities			660,205	660,205		660,205	(183,162)	477,043		5
6	Maintenance	191,176	19,498	48,792	259,466		259,466	(69,099)	190,367		6
7	Other (specify):* Home Off. Ben. All.							1,169	1,169		7
8	<b>TOTAL General Services</b>	<b>809,537</b>	<b>352,370</b>	<b>708,997</b>	<b>1,870,904</b>		<b>1,870,904</b>	<b>(511,844)</b>	<b>1,359,060</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	1,913,285	98,746	64,082	2,076,113		2,076,113	(2,422)	2,073,691		10
10a	Therapy	299,055	302	8,499	307,856		307,856	(86,713)	221,143		10a
11	Activities	119,869	1,675	2,717	124,261		124,261		124,261		11
12	Social Services	106,306	244		106,550		106,550		106,550		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							483	483		15
16	<b>TOTAL Health Care and Programs</b>	<b>2,438,515</b>	<b>100,967</b>	<b>84,298</b>	<b>2,623,780</b>		<b>2,623,780</b>	<b>(88,652)</b>	<b>2,535,128</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	45,388		190,000	235,388		235,388	(129,541)	105,847		17
18	Directors Fees										18
19	Professional Services			14,774	14,774		14,774	9,078	23,852		19
20	Dues, Fees, Subscriptions & Promotions			4,807	4,807		4,807	1,957	6,764		20
21	Clerical & General Office Expenses	77,951	5,194	28,807	111,952		111,952	65,580	177,532		21
22	Employee Benefits & Payroll Taxes			517,676	517,676		517,676		517,676		22
23	Inservice Training & Education			1,310	1,310		1,310	674	1,984		23
24	Travel and Seminar							208	208		24
25	Other Admin. Staff Transportation			1,872	1,872		1,872	3,253	5,125		25
26	Insurance-Prop.Liab.Malpractice			88,353	88,353		88,353	1,350	89,703		26
27	Other (specify):* Home Off. Ben. All.							17,722	17,722		27
28	<b>TOTAL General Administration</b>	<b>123,339</b>	<b>5,194</b>	<b>847,599</b>	<b>976,132</b>		<b>976,132</b>	<b>(29,719)</b>	<b>946,413</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,371,391</b>	<b>458,531</b>	<b>1,640,894</b>	<b>5,470,816</b>		<b>5,470,816</b>	<b>(630,215)</b>	<b>4,840,601</b>		<b>29</b>

\*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.

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#0050294

Report Period Beginning:

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			463	463		463	56,343	56,806			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							193,521	193,521			32
33	Real Estate Taxes							109,120	109,120			33
34	Rent-Facility & Grounds			608,020	608,020		608,020	(608,020)				34
35	Rent-Equipment & Vehicles			18,619	18,619		18,619	784	19,403			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			627,102	627,102		627,102	(248,252)	378,850			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,269		90,269		90,269		90,269			39
40	Barber and Beauty Shops			787	787		787		787			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify):* <b>Non-allowable Cost</b>	29,780	1,184	84,476	115,440		115,440	(115,440)				43
44	<b>TOTAL Special Cost Centers</b>	29,780	91,453	152,058	273,291		273,291	(115,440)	157,851			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,401,171	549,984	2,420,054	6,371,209		6,371,209	(993,907)	5,377,302			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(22,073)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(58,250)	30		9
10	Interest and Other Investment Income	(382)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(176)	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	(5,938)	43		18
19	Entertainment				19
20	Contributions	(30,000)	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	(39,225)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(672,428)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (828,472)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(165,435)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (165,435)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (993,907)		37

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

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

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

<b>BHF USE ONLY</b>							
48		49		50		51	52

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,922)	43	1
2	X-Rays-Part A	(6,345)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(6,341)	10	3
4	Offset Miscellaneous Food Revenue	(2,610)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(441)	21	5
6	Offset Chamber of Commerce Dues	(573)	20	6
7	Offset Therapy Revenue	(86,713)	10a	7
8	Resident Flowers	(556)	43	8
9	Disallowed Special Events	(3,582)	43	9
10	Pet Expense	(1,623)	43	10
11	Offset Independent Living Depreciation	(36,863)	30	11
12	Offset Independent Living Dietary	(113,467)	1	12
13	Offset Independent Living Food	(68,775)	2	13
14	Offset Independent Living Housekeeping	(49,615)	3	14
15	Offset Independent Living Laundry	(32,966)	4	15
16	Offset Independent Living Utilities	(183,801)	5	16
17	Offset Independent Living Maintenance	(72,235)	6	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				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	<b>Total</b>	(672,428)		49

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VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 6,475	\$ 6,475	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	145	145	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	61	61	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	639	639	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,136	3,136	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,169	1,169	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,919	3,919	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	483	483	10
11	V	17 Administrative	190,000	Petersen Health Care, Inc.	100.00%	60,459	(129,541)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	9,078	9,078	12
13	V							13
14	Total		\$ 190,000			\$ 85,564	\$ * (104,436)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 2,530	\$	2,530	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	66,021		66,021	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	674		674	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	208		208	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,253		3,253	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,350		1,350	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	17,722		17,722	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,336		5,336	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	8,208		8,208	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	820		820	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	784		784	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	<b>Total</b>		\$			\$ 106,906	\$ *	106,906	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	30	Depreciation	\$	Petersen Health Care VII, Inc.	100.00%	\$ 146,120	\$	146,120	15
16	V	32	Amortization		Petersen Health Care VII, Inc.	100.00%	1,900		1,900	16
17	V	32	Interest		Petersen Health Care VII, Inc.	100.00%	183,795		183,795	17
18	V	33	Real Estate Taxes		Petersen Health Care VII, Inc.	100.00%	108,300		108,300	18
19	V	34	Rent-Facility and Grounds	608,020	Petersen Health Care VII, Inc.	100.00%	0		(608,020)	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			\$ 608,020			\$ 440,115	\$ *	(167,905)	39

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

Facility Name &amp; ID Number

Mason Point

# 0050294

Report Period Beginning:

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## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	154,904	1.45	2.41	Salary	\$ 4,209	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,209		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:

1/1/2009Ending: 2/31/2009

## VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

( 309) 691-8113

Fax Number

( 309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	37,024	\$ 6,475	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	37,024	145	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	37,024	61	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	37,024	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	37,024	639	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	37,024	3,136	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	37,024	1,169	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	37,024	3,919	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	37,024	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	37,024	483	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	37,024	60,459	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	37,024	9,078	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	37,024	2,530	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	37,024	66,021	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	37,024	674	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	37,024	208	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	37,024	3,253	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	37,024	1,350	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	37,024	17,722	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	37,024	5,336	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	37,024	8,208	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	37,024	820	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	37,024	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	37,024	784	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 192,470	25

Facility Name & ID Number

Mason Point

# 0050294

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

**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										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related Long-Term</b>																			
1	Illinois Masonic Home	X	Mortgage	Varies	1/1/2009	\$ 3,510,000	\$ 3,085,775	12/31/09	Varies	\$ 183,795	1								
2											2								
3						Interest Income Offset				(382)	3								
4						Home Office Allocation-PHC				8,208	4								
5											5								
<b>Working Capital</b>																			
6											6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>					\$ 3,510,000	\$ 3,085,775			\$ 191,621	9								
<b>B. Non-Facility Related*</b>																			
10						Amortization of Loan Costs				1,900	10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$ 1,900	14								
15	<b>TOTALS (line 9+line14)</b>					\$ 3,510,000	\$ 3,085,775			\$ 193,521	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2008	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>Home Office Allocation</b>		\$	820
<b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	109,120
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	8	
	2005	9	
	2006	10	
	2007	11	
	2008	12	
<b>No real estate taxes were paid due to the facility being a not-for-profit facility in 2008.</b>			
			<b>FOR BHF USE ONLY</b>
	13	FROM R. E. TAX STATEMENT FOR 2008 \$	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.**



Facility Name & ID Number Mason Point

# 0050294 Report Period Beginning:

1/1/2009 Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

Independent Apartments-28,244 square feet, 27 units

Duplexes-44,320 square feet, 27 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name & ID Number Mason Point

# 0050294

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	2009	1950	\$ 2,045,700	\$	25	\$ 40,914	\$ 40,914	\$ 40,914	4
5	24	1955							5
6	72	1983							6
7	50	1986							7
8	48	1981							8
<b>Improvement Type**</b>									
9	Generator Repair	2009	2,937		7	210	210	210	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
31									31
32	2009-Home Office Allocation-Land Improvements		1,218			77	77		32
33	2009-Home Office Allocation-Building Improvements		18,201			437	437		33
34									34
35									35
36									36

\*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	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)	\$	2,068,056	\$		\$	41,638	\$	41,638	\$	41,124	70

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

**XI. OWNERSHIP COSTS (continued)**

**C. Equipment Depreciation-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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<b>196,646</b>	<b>463</b>	<b>9,832</b>	<b>9,369</b>	<b>10 yrs.</b>	<b>9,832</b>	72
73	Fully Depreciated Assets							73
74	<b>Home Office Allocation</b>			<b>5,336</b>	<b>5,336</b>			74
75	<b>TOTALS</b>	<b>\$ 196,646</b>	<b>\$ 463</b>	<b>\$ 15,168</b>	<b>\$ 14,705</b>		<b>\$ 9,832</b>	75

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	<b>TOTALS</b>			<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>		<b>\$</b>	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)	\$ 2,574,002	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 463	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,806	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 56,343	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 50,956	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	<b>Duplexes, Apartments, Other Bldg.</b>	<b>\$ 776,000</b>	<b>\$ 36,863</b>	<b>\$ 36,863</b>	86
87					87
88					88
89					89
90					90
91	<b>TOTALS</b>	<b>\$ 776,000</b>	<b>\$ 36,863</b>	<b>\$ 36,863</b>	91

**G. Construction-in-Progress**

	Description	Cost	
92		\$	92
93	<b>N/A</b>		93
94			94
95		\$	95

\* **Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.**

\*\* **This must agree with Schedule V line 30, column 8.**

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 19,403 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			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

\* 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**  
**Period End**

**1/1/2009**  
**12/31/2009**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$	3,477
Dishwasher	\$	600
Maintenance Equipment		101
Copier		14,441
Home Office Allocation		784
		<u>19,403</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	1434	hrs	\$ 37,016		\$	\$	1,434	\$ 37,016	1
2	Licensed Speech and Language Development Therapist	10A(3)	64	hrs	4,388	259	3,892	121	323	8,401	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	7997	hrs	257,651	2	28	181	7,999	257,860	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 prescripts				90,269		90,269	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): _____										12
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)				305	4,579		305	4,579	13
14	<b>TOTAL</b>				\$ 299,055	566	\$ 8,499	\$ 90,571	10,061	\$ 398,125	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# 0050294Report Period Beginning: 1/1/2009Ending: 12/31/2009

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ (76,223)	\$ (76,223)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	742,218	742,218	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	94,485	94,485	6
7	Other Prepaid Expenses	25,270	25,270	7
8	Accounts Receivable (owners or related parties)	715	715	8
9	Other(specify): <u>Employee Advances</u>	89	89	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 786,554	\$ 786,554	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		309,300	13
14	Buildings, at Historical Cost		2,063,901	14
15	Leasehold Improvements, at Historical Cost	2,937	4,155	15
16	Equipment, at Historical Cost	4,646	196,646	16
17	Accumulated Depreciation (book methods)	(463)	(50,956)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		554,600	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(1,900)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Independent Living Facility</u>		770,137	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 7,120	\$ 3,845,883	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 793,674	\$ 4,632,437	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 562,577	\$ 562,577	26
27	Officer's Accounts Payable	(120,000)	(120,000)	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	122,616	122,616	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,112	9,112	31
32	Accrued Real Estate Taxes(Sch.IX-B)		108,300	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	148,285	148,285	36
37	<u>Security Deposit-Residents</u>	7,685	7,685	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 730,275	\$ 838,575	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,085,775	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Due To Related Parties</u>	293,100	691,700	43
44	<u>A/P-Prior Owner</u>	9,242	9,242	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 302,342	\$ 3,786,717	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,032,617	\$ 4,625,292	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (238,943)	\$ 7,145	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 793,674	\$ 4,632,437	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(36,889)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	(202,054)	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (238,943)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (238,943)	<b>24</b> *

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

Facility Name & ID Number Mason Point# 0050294Report Period Beginning: 1/1/2009Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,221,852	1
2	Discounts and Allowances for all Levels	127,476	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,349,328</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	943,539	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 943,539</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	30,104	13
14	Non-Patient Meals	2,610	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	95,512	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,501	20
21	Other Medical Services	1,815,849	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 1,947,576</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	382	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 382</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	6,782	28
28a	Therapy Revenue From Related Parties	86,713	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 93,495</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 6,334,320</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,870,904	31
32	Health Care	2,623,780	32
33	General Administration	976,132	33
<b>B. Capital Expense</b>			
34	Ownership	627,102	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	206,496	35
36	Provider Participation Fee	66,795	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 6,371,209</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(36,889)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (36,889)</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is reported on owners 1040 Schedule C.

\*\*\* 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:

**1/1/2009**

Ending:

**12/31/2009**

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 60,322	\$ 29.00	1
2	Assistant Director of Nursing	2,072	2,072	53,874	26.00	2
3	Registered Nurses	2,822	2,822	68,565	24.30	3
4	Licensed Practical Nurses	29,168	29,208	594,314	20.35	4
5	CNAs & Orderlies	84,971	85,031	1,051,842	12.37	5
6	CNA Trainees					6
7	Licensed Therapist	4,716	4,716	178,887	37.93	7
8	Rehab/Therapy Aides	4,739	4,779	120,168	25.15	8
9	Activity Director					9
10	Activity Assistants	6,166	6,166	63,641	10.32	10
11	Social Service Workers	9203	9,259	106,306	11.48	11
12	Dietician					12
13	Food Service Supervisor	1,863	1,863	18,627	10.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	39,404	39,481	364,559	9.23	15
16	Dishwashers					16
17	Maintenance Workers	11,213	11,237	191,176	17.01	17
18	Housekeepers	15,477	15,477	145,092	9.37	18
19	Laundry	9,397	9,508	90,083	9.47	19
20	Administrator	2,080	2,080	75,000	36.06	20
21	Assistant Administrator	1,990	1,990	26,638	13.39	21
22	Other Administrative					22
23	Office Manager	4,795	4,795	77,951	16.26	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	204	204	1,632	8.00	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached PG2</u>	11,439	11,439	168,744	14.75	33
34	TOTAL (lines 1 - 33)	243,799	244,207	\$ 3,457,421 *	\$ 14.16	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	9,000	9(3)	36
37	Medical Records Consultant	Monthly	390	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,500	10(3)	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) <u>Dentist</u>	4 visits	2,040	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,930		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	33	1,171	10(3)	51
52	Certified Nurse Assistants/Aides	2,417	51,645	10(3)	52
53	TOTAL (lines 50 - 52)	2,450	\$ 52,815		53

Mason Point

0050294

Period Beginning 1/1/2009

Period End 12/31/2009

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	3,967	3,967	82,736	20.86
Marketing	2,081	2,081	29,780	14.31
Transportation	5,391	5,391	56,228	10.43
Physical Therapy Aide				
<b>TOTAL (lines 1 - 35)</b>	<b>11,439</b>	<b>11,439</b>	<b>168,744</b>	

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Darin Wall	Adminstrator	0	\$ 75,000	Workers' Compensation Insurance	\$ 97,820	IDPH License Fee	\$ 518	
Jennifer Martin	Asst. Administrator	0	26,638	Unemployment Compensation Insurance	66,512	Advertising: Employee Recruitment	461	
				FICA Taxes	253,670	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	48,832	<u>Patient Background Checks</u>	<u>125</u> 1,250	
				Employee Meals		Miscellaneous Licenses & Permits	2,005	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	573	
				<u>Employee Relations</u>	<u>50,842</u>	IHCA Dues		
				<u>Employee Retirement</u>		Home Office Allocation	2,530	
				<u>Employee Life Insurance</u>				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 101,638			Less: Public Relations Expense	(573)	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ 190,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 190,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 517,676	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,764	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>American Healthtech</u>	<u>Computer Services</u>		\$ 9,806				Out-of-State Travel	\$
<u>IVANS</u>	<u>Computer Services</u>		247					
<u>Consistent Computer Bargains</u>	<u>Computer Services</u>		688					
<u>Simple LTC, Inc.</u>	<u>Computer Services</u>		81	<u>N/A</u>			In-State Travel	
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		2,742					
<u>Travis Hubbard</u>	<u>Computer Repairs</u>		1,210				Seminar Expense	
							<u>Home Office Allocation</u>	208
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 14,774	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 208

\* Attach copy of IMRF notifications

\*\*See instructions.

**Mason Point**

**0050294**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		14,774

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	58
GoffWilson, P.A.	Legal	82
Jackson Lewis	Legal	650
Peter Gartelos	Legal	63
Misc.	Legal	56
Ginoli & Company	Accountants	1,444
Miscellaneous Vendors	Computer Services	60
Emdeon Business Services	Computer Services	27
Advanced Answers on Demand	Computer Services	3,488
Access 2 Go	Computer Services	335
Ivans	Computer Services	40
Kemper Technology	Computer Services	948
VisionShare	Computer Services	295
MediFax	Computer Services	120
LogmeIn	Computer Services	52
Charter Communications	Computer Services	2
Simple LTC	Computer Services	805
Miscellaneous Vendors	Miscellaneous	553
Total (agree to Schedule V, line 19, column 8)		<u>23,852</u>



Facility Name & ID Number Mason Point# 0050294Report Period Beginning: 1/1/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (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? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,089 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? N/A  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 66,795  
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? Yes 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.  
**See attached schedule 23a**
- (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. \$ 2,610
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? N/A**  
**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? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**Mason Point**  
**0050294**  
**Period Beginning 1/1/2009**  
**Period End 12/31/2009**

**Independent Living Offset**

**Schedule 23A**

<b>Census Days Summary:</b>	<b>Days</b>	<b>%</b>
Independent Living	14,281	27.84%
Nursing Home	37,024	72.16%
	<u>51,305</u>	<u>100.00%</u>

<b>Expense Offset:</b>	<b>Total Amount</b>	<b>Ind. Liv %</b>	<b>Ind. Liv Offset</b>	<b>Basis For Allocation</b>	<b>Line</b>
Dietary	407,568	27.84%	113,467	Census	1
Food	247,038	27.84%	68,775	Census	2
Housekeeping	178,215	27.84%	49,615	Census	3
Laundry	118,412	27.84%	32,966	Census	4
Utilities	660,205	27.84%	183,801	Census	5
Maintenance	259,466	27.84%	72,235	Census	6
Depreciation (Building)	<u>36,863</u>	100.00%	<u>36,863</u>	S/L Depr	30
<b>Total</b>	<u>1,907,767</u>		<u>557,722</u>		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on straight-line depreciation over an estimated useful life of 25 years. Independent Living overhead and depreciation cost have been offset on P5A.