

Facility Name & ID Number Mason Point

0050294 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,770	11,354	3,784	17,908	8
9	SNF/PED					9
10	ICF	18,250			18,250	10
11	ICF/DD					11
12	SC			751	751	12
13	DD 16 OR LESS					13
14	TOTALS	21,020	11,354	4,535	36,909	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.48%

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 72 and days of care provided 3,784

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	393,561	22,723	1,422	417,706		417,706	(128,565)	289,141		1
2	Food Purchase		301,268		301,268		301,268	(108,458)	192,810		2
3	Housekeeping	161,977	47,958		209,935		209,935	(68,199)	141,736		3
4	Laundry	102,474	40,486		142,960		142,960	(49,791)	93,169		4
5	Heat and Other Utilities			668,197	668,197		668,197	(246,218)	421,979		5
6	Maintenance	232,040	50,621	52,960	335,621		335,621	(105,581)	230,040		6
7	Other (specify):* Home Off. Ben. All.							411	411		7
8	TOTAL General Services	890,052	463,056	722,579	2,075,687		2,075,687	(706,401)	1,369,286		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	2,223,944	155,731	8,538	2,388,213		2,388,213	26	2,388,239		10
10a	Therapy	675,924	266		676,190		676,190	(482,851)	193,339		10a
11	Activities	211,300	825	130	212,255		212,255	(82,783)	129,472		11
12	Social Services	87,199	161	677	88,037		88,037		88,037		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	3,198,367	156,983	18,345	3,373,695		3,373,695	(565,608)	2,808,087		16
	C. General Administration										
17	Administrative			310,000	310,000		310,000	(230,175)	79,825		17
18	Directors Fees										18
19	Professional Services			77,831	77,831		77,831	15,334	93,165		19
20	Dues, Fees, Subscriptions & Promotions			6,026	6,026		6,026	(1,345)	4,681		20
21	Clerical & General Office Expenses	70,965	32,819	82,638	186,422		186,422	82,545	268,967		21
22	Employee Benefits & Payroll Taxes			408,782	408,782		408,782	(50,954)	357,828		22
23	Inservice Training & Education			21,334	21,334		21,334	145	21,479		23
24	Travel and Seminar							7	7		24
25	Other Admin. Staff Transportation			49,508	49,508		49,508	6,733	56,241		25
26	Insurance-Prop.Liab.Malpractice			70,468	70,468		70,468	1,300	71,768		26
27	Other (specify):* Home Off. Ben. All.							8,343	8,343		27
28	TOTAL General Administration	70,965	32,819	1,026,587	1,130,371		1,130,371	(168,067)	962,304		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,159,384	652,858	1,767,511	6,579,753		6,579,753	(1,440,076)	5,139,677		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:

1/1/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			8,492	8,492		8,492	105,674	114,166			30
31	Amortization of Pre-Op. & Org.							657	657			31
32	Interest			27,975	27,975		27,975	137,135	165,110			32
33	Real Estate Taxes							139,516	139,516			33
34	Rent-Facility & Grounds			398,751	398,751		398,751	(398,751)				34
35	Rent-Equipment & Vehicles			31,625	31,625		31,625	1,077	32,702			35
36	Other (specify):*											36
37	TOTAL Ownership			466,843	466,843		466,843	(14,692)	452,151			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,556		107,556		107,556		107,556			39
40	Barber and Beauty Shops			1,605	1,605		1,605	(1,605)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			275,785	275,785		275,785		275,785			42
43	Other (specify):* Non-allowable Costs	43,253	6,528	426,807	476,588		476,588	(476,588)				43
44	TOTAL Special Cost Centers	43,253	114,084	704,197	861,534		861,534	(478,193)	383,341			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,202,637	766,942	2,938,551	7,908,130		7,908,130	(1,932,961)	5,975,169			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: 1/1/2013

Ending: 12/31/2013

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	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,642)	2		4
5	Telephone, TV & Radio in Resident Rooms	(13,957)	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	(9,558)	30		9
10	Interest and Other Investment Income	(39,099)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(494)	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	(163,510)	43		18
19	Entertainment				19
20	Contributions	(21,021)	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	(136,845)	43		24
25	Fund Raising, Advertising and Promotional	(60,744)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(1,452,769)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,908,639)		\$	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	2	
		Amount	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)	(24,322)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (24,322)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (1,932,961)		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	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Mason Point

Report Period Beginning:	ID#	0050294
Ending:		1/1/2013
		12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (12,141)	43	1
2	X-Rays-Part A	(6,181)	43	2
3	Offset Privately Paid Electricity	(29,472)	5	3
4	Offset Transportation Revenue	(82,783)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(5,229)	21	5
6	Offset Chamber of Commerce Dues	(2,320)	20	6
7	Offset Therapy Revenue	(482,851)	10A	7
8	Resident Flowers	(1,125)	43	8
9	Disallowed Special Events	(287)	43	9
10	Pet Expense	(1,316)	43	10
11	Offset Independent Living Depreciation	(36,863)	30	11
12	Offset Independent Living Dietary	(135,838)	1	12
13	Offset Independent Living Food	(97,972)	2	13
14	Offset Independent Living Housekeeping	(68,271)	3	14
15	Offset Independent Living Laundry	(46,491)	4	15
16	Offset Independent Living Utilities	(217,298)	5	16
17	Offset Independent Living Maintenance	(109,144)	6	17
18	Offset Laundry Equipment Rental Revenue	(3,300)	4	18
19	Offset Benefits on Therapy Revenue	(50,954)	33	19
20	Offset Privately Paid Telephone	(2,361)	21	20
21	Disallowed Air Travel Expense	(57,675)	43	21
22	Offset Barber and Beauty Revenue	(1,605)	31	22
23	Offset Vending Machine Expense	(1,292)	43	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	(1,452,769)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mason Point# 0050294

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	(135,838)	7,273	0	0	0	0	0	0	0	0	0	(128,565)	1
2	Food Purchase	(108,614)	156	0	0	0	0	0	0	0	0	0	(108,458)	2
3	Housekeeping	(68,271)	72	0	0	0	0	0	0	0	0	0	(68,199)	3
4	Laundry	(49,791)	0	0	0	0	0	0	0	0	0	0	(49,791)	4
5	Heat and Other Utilities	(246,770)	552	0	0	0	0	0	0	0	0	0	(246,218)	5
6	Maintenance	(109,144)	3,563	0	0	0	0	0	0	0	0	0	(105,581)	6
7	Other (specify):*	0	411	0	0	0	0	0	0	0	0	0	411	7
8	TOTAL General Services	(718,428)	12,027	0	0	0	0	0	0	0	0	0	(706,401)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	26	0	0	0	0	0	0	0	0	0	26	10
10a	Therapy	(482,851)	0	0	0	0	0	0	0	0	0	0	(482,851)	10a
11	Activities	(82,783)	0	0	0	0	0	0	0	0	0	0	(82,783)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(565,634)	26	0	0	0	0	0	0	0	0	0	(565,608)	16
	C. General Administration													
17	Administrative	0	(230,175)	0	0	0	0	0	0	0	0	0	(230,175)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,334	0	0	0	0	0	0	0	0	0	15,334	19
20	Fees, Subscriptions & Promotions	(2,320)	0	975	0	0	0	0	0	0	0	0	(1,345)	20
21	Clerical & General Office Expenses	(7,590)	0	90,135	0	0	0	0	0	0	0	0	82,545	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	145	0	0	0	0	0	0	0	0	145	23
24	Travel and Seminar	0	0	7	0	0	0	0	0	0	0	0	7	24
25	Other Admin. Staff Transportation	0	0	6,733	0	0	0	0	0	0	0	0	6,733	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,300	0	0	0	0	0	0	0	0	1,300	26
27	Other (specify):*	0	0	8,343	0	0	0	0	0	0	0	0	8,343	27
28	TOTAL General Administration	(9,910)	(214,841)	107,638	0	(117,113)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,293,972)	(202,788)	107,638	0	(1,389,122)	29							

STATE OF ILLINOIS

Facility Name & ID Number Mason Point# 0050294

Report Period Beginning:

1/1/2013 Ending:

Summary B

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(46,421)	0	5,975	146,120	0	0	0	0	0	0	0	105,674	30
31	Amortization of Pre-Op. & Org.	(1,605)	0	0	657	0	0	0	0	0	0	0	(948)	31
32	Interest	(39,099)	0	9,939	166,295	0	0	0	0	0	0	0	137,135	32
33	Real Estate Taxes	(50,954)	0	585	138,931	0	0	0	0	0	0	0	88,562	33
34	Rent-Facility & Grounds	0	0	0	(398,751)	0	0	0	0	0	0	0	(398,751)	34
35	Rent-Equipment & Vehicles	0	0	1,077	0	0	0	0	0	0	0	0	1,077	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(138,079)	0	17,576	53,252	0	(67,251)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(476,588)	0	0	0	0	0	0	0	0	0	0	(476,588)	43
44	TOTAL Special Cost Centers	(476,588)	0	0	0	0	0	0	0	0	0	0	(476,588)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(1,908,639)	(202,788)	125,214	53,252	0	0	0	0	0	0	0	(1,932,961)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 7,273	\$ 7,273	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	156	156	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	72	72	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	552	552	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,563	3,563	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	411	411	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	26	26	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	310,000	Petersen Health Care, Inc.	100.00%	79,825	(230,175)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	15,334	15,334	12
13	V							13
14	Total		\$ 310,000			\$ 107,212	\$ * (202,788)	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 & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 975	\$	975	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	90,135		90,135	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	145		145	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	7		7	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	6,733		6,733	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,300		1,300	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,343		8,343	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,975		5,975	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	9,939		9,939	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	585		585	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	1,077		1,077	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		\$			\$ 125,214	\$ *	125,214	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 Clerical and General Office	\$	Petersen Health Care VII, LLC	100.00%	\$		15
16	V	30 Depreciation		Petersen Health Care VII, LLC	100.00%	146,120	146,120	16
17	V	32 Interest		Petersen Health Care VII, LLC	100.00%	166,295	166,295	17
18	V	31 Amortization		Petersen Health Care VII, LLC	100.00%	657	657	18
19	V	33 Real Estate Taxes		Petersen Health Care VII, LLC	100.00%	138,931	138,931	19
20	V	34 Rent-Facility and Grounds	398,751	Petersen Health Care VII, LLC	100.00%	0	(398,751)	20
21	V				100.00%	0		21
22	V				100.00%	0		22
23	V				100.00%	0		23
24	V				100.00%	0		24
25	V				100.00%	0		25
26	V				100.00%	0		26
27	V				100.00%	0		27
28	V				100.00%	0		28
29	V				100.00%	0		29
30	V				100.00%	0		30
31	V				100.00%	0		31
32	V				100.00%	0		32
33	V				100.00%	0		33
34	V				100.00%	0		34
35	V				100.00%	0		35
36	V				100.00%	0		36
37	V				100.00%	0		37
38	V				100.00%	0		38
39	Total		\$ 398,751			\$ 452,003	\$ * 53,252	39

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

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				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: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mason Point

0050294

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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	1,560,986	75	\$ 307,592	\$ 295,212	36,909	\$ 7,273	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	36,909	156	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	36,909	72	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	36,909	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	36,909	552	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	36,909	3,563	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	36,909	411	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	36,909	26	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	36,909	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	36,909	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	36,909	79,825	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	36,909	15,334	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	36,909	975	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	36,909	90,135	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	36,909	145	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	36,909	7	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	36,909	6,733	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	36,909	1,300	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	36,909	8,343	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	36,909	5,975	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	36,909	9,939	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	36,909	585	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	36,909	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	36,909	1,077	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 232,426	25

Facility Name & ID Number

Mason Point

0050294

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	Name of Lender	2		3	4	5	6		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			
A. Directly Facility Related																	
Long-Term																	
1	First Financial Bank		X	Mortgage	\$21,630.60	11/1/2010	3,042,908	\$ 2,766,008	11/01/2030	0.0590	\$ 166,295						
2																	
3																	
4																	
5																	
Working Capital																	
6	First Financial Bank		X	Line of Credit	Varies	3/31/2013	799,022	490,387	3/31/2014	Varies	27,975						
7																	
8																	
9	TOTAL Facility Related				\$21,630.60		\$ 3,841,930	\$ 3,256,395			\$ 194,270						
B. Non-Facility Related*																	
10											(39,099)						
11											9,939						
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$ (29,160)						
15	TOTALS (line 9+line14)						\$ 3,841,930	\$ 3,256,395			\$ 165,110						

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

* 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.)

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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:

1/1/2013 Ending:

12/31/2013

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

N/A

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

1. Total Amount Incurred: 14,323 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 657 4. Dates Incurred: 2013

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>	1
2					2
3	TOTALS	1,568,160		\$ 309,300	3

Facility Name & ID Number Mason Point

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	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	\$ 81,828	\$ 81,828	\$ 368,226
5	24		1955						
6	72		1983						
7	50		1986						
8	48		1981						
Improvement Type**									
9	Generator Repair		2009	2,937		7	420	420	1,890
10	Automatic Door Opener/Closer		2010	8,185		15	546	546	1,911
11	Roof Repairs		2011	9,265		7	1,324	1,324	5,296
12	Elevator Repair		2012	4,817		7	688	688	1,032
13	Water Tower Repair		2013	2,725		7	195	195	195
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	Building Booked				81,828			(81,828)	
32	Building Improvement Booked				3,009			(3,009)	
33									
34	2013-Home Office Allocation-Building Improvements			17,355			416	416	
35	2013-Home Office Allocation-Land Improvements			1,620			104	104	
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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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)	\$ 2,092,604	\$ 84,837		\$ 85,521	\$ 684	\$ 378,550	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 222,864	\$ 31,838	\$ 22,287	\$ (9,551)	5-10 yrs.	\$ 95,131	71
72	Current Year Purchases	18,053	1,074	903	(171)	10 yrs.	903	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,455	5,455			74
75	TOTALS	\$ 240,917	\$ 32,912	\$ 28,645	\$ (4,267)		\$ 96,034	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 2,642,821	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,749	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 114,166	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,583)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 474,584	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Duplexes, Apartments, Other Bldg.	\$ 776,000	\$ 36,863	\$ 184,317	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 776,000	\$ 36,863	\$ 184,317	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: 1/1/2013

Ending: 12/31/2013

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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 32,702 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	<u>N/A</u>				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 1/1/2013

Period End 12/31/2013

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 4,697
Dishwasher	1,148
Laundry Equipment	-
Copier	25,780
Home Office Allocation	1,077
	<u>32,702</u>

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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	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.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5 Units Cost					
					Units	Cost				
1	Licensed Occupational Therapist	10A(1)	2356 hrs	\$ 68,137		\$	\$	2,356	\$ 68,137	1
2	Licensed Speech and Language Development Therapist	10A(1)	2212 hrs	98,332				2,212	98,332	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1), 10A(2)	15722 hrs	509,455			266	15,722	509,721	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				107,556		107,556	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			\$ 675,924		\$	\$ 107,822	20,290	\$ 783,746	14

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

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 68,648	\$ 68,648	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>239,451</u>)	1,293,864	1,293,864	3
4	Supply Inventory (priced at)	21,685	21,685	4
5	Short-Term Investments			5
6	Prepaid Insurance	63,625	63,625	6
7	Other Prepaid Expenses	61,032	61,032	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit & Emp. Loans</u>	25,041	25,041	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,533,895	\$ 1,533,895	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		2,063,055	14
15	Leasehold Improvements, at Historical Cost	27,929	29,549	15
16	Equipment, at Historical Cost	48,917	240,917	16
17	Accumulated Depreciation (book methods)	(21,540)	(474,584)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	577,000	577,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		2,781	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>N/R-Mark Petersen</u>)	370,068	370,068	22
23	Other(specify): <u>Independent Living Facility</u>		591,683	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,002,374	\$ 3,709,769	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,536,269	\$ 5,243,664	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,244,859	\$ 1,244,859	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	490,387	490,387	29
30	Accrued Salaries Payable	141,458	141,458	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,415	8,415	31
32	Accrued Real Estate Taxes(Sch.IX-B)		143,364	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	199,726	199,726	36
37	<u>Accrued Management Fees</u>	240,532	240,532	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,325,377	\$ 2,468,741	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,766,008	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due To Related Parties</u>	623,364	67,387	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 623,364	\$ 2,833,395	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,948,741	\$ 5,302,136	46
47	TOTAL EQUITY(page 18, line 24)	\$ (412,472)	\$ (58,472)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,536,269	\$ 5,243,664	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (194,057)	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (194,060)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	31,588	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	(250,000)	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)	\$ (218,412)	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)	\$ (412,472)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mason Point# 0050294Report Period Beginning: 1/1/2013Ending: 12/31/2013

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,733,173	1
2	Discounts and Allowances for all Levels	(486,011)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,247,162	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	709,312	6
7	Oxygen	3,435	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 712,747	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	48,394	13
14	Non-Patient Meals	10,642	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	174,068	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	15,640	20
21	Other Medical Services	35,016	21
22	Laundry	3,300	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 287,060	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	39,099	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,099	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous & Transportation Revenue	119,845	28
28a	Therapy Revenue From Related Parties	533,805	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 653,650	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,939,718	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	2,075,687	31
32	Health Care	3,373,695	32
33	General Administration	1,130,371	33
B. Capital Expense			
34	Ownership	466,843	34
C. Ancillary Expense			
35	Special Cost Centers	585,749	35
36	Provider Participation Fee	275,785	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,908,130	40
41	Income before Income Taxes (line 30 minus line 40)**	31,588	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 31,588	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,669,170	44
45	Private Pay - Net Inpatient Revenue	2,412,314	45
46	Medicare - Net Inpatient Revenue	859,063	46
47	Other-(specify) <u>Independent Living</u>	313,370	47
48	Other-(specify) <u>Charity Therapy Allowance</u>	(6,755)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 6,247,162	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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:

1/1/2013

Ending:

12/31/2013

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	\$ 72,306	\$ 34.76	1
2	Assistant Director of Nursing	2,080	2,080	55,704	26.78	2
3	Registered Nurses	5,413	5,477	129,954	23.73	3
4	Licensed Practical Nurses	30,058	31,097	639,391	20.56	4
5	CNAs & Orderlies	105,231	105,918	1,233,251	11.64	5
6	CNA Trainees					6
7	Licensed Therapist	6,038	6,070	269,851	44.46	7
8	Rehab/Therapy Aides	13,680	14,220	406,073	28.56	8
9	Activity Director	3,993	4,075	52,771	12.95	9
10	Activity Assistants	5,426	5,875	65,694	11.18	10
11	Social Service Workers	6,421	6,673	87,199	13.07	11
12	Dietician					12
13	Food Service Supervisor	4,108	4,108	57,222	13.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	36,540	37,171	336,339	9.05	15
16	Dishwashers					16
17	Maintenance Workers	13,061	13,723	232,040	16.91	17
18	Housekeepers	16,029	16,687	161,977	9.71	18
19	Laundry	10,362	11,108	102,474	9.23	19
20	Administrator	2,080	2,080	79,825	38.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,070	4,344	70,965	16.34	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	14,386	14,850	229,426	15.45	33
34	TOTAL (lines 1 - 33)	281,056	287,636	\$ 4,282,462 *	\$ 14.89	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	28	\$ 1,422	L1, C3	35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,000	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	65	677	L10, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	93	\$ 16,099		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Mason Point
0050294
Period Beginning
Period End

1/1/2013
12/31/2013

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	4,160	4,160	93,338	22.44
Transportation	8,146	8,610	92,835	10.78
Marketing	2,080	2,080	43,253	20.79
TOTAL	14,386	14,850	229,426	

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	Administrator	0	\$ 79,825	Workers' Compensation Insurance	\$ 80,135	IDPH License Fee	\$			
				Unemployment Compensation Insurance	68,667	Advertising: Employee Recruitment	81			
				FICA Taxes	255,289	Health Care Worker Background Check				
				Employee Health Insurance	(81,424)	(Indicate # of checks performed)				
				Employee Meals		Patient Background Checks	107			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	2,430			
				Employee Relations	32,807	Miscellaneous Dues & Subscriptions	2,445			
				Employee Retirement	2,354	Home Office Allocation	975			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 79,825	TOTAL (agree to Schedule V, line 22, col.8)			\$ 357,828	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,681
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 310,000				Out-of-State Travel	\$		
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 310,000				Seminar Expense			
C. Professional Services							Home Office Allocation	7		
Vendor/Payee	Type		Amount							
Odessian LLC	Computer Services		\$ 1,125				Entertainment Expense	()		
Empower Software Solutions	Computer Services		6,207				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 7	
Heart Technologies	Computer Services		1,736							
Ginoli and Company	Accounting Services		2,550	N/A						
Honkamp Krueger & Co.	Accounting Services		1,862							
Annie Parks	Consulting Fees		42,083							
Sorling , Northrup, Hanna	Legal Services		14,304							
One-Eleven Internet Service	Computer Services		709							
Gail and Rice	Accounting Services		7,031							
Moultrie County Circuit Clerk	Filing Fees		155							
Moultrie County Sheriff	Filing Fees		69							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 77,831	TOTAL			\$			

* Attach copy of IMRF notifications

**See instructions.

Mason Point

0050294

Period Beginning

1/1/2013

Period End

12/31/2013

Schedule 21A**XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		77,831
Home Office Allocation		
SmithAmundsen	Legal	911
Cole, Schotz, Meisel	Legal	502
Black, Hedin, Ballard	Legal	45
Ginoli & Company	Accountants	1660
Miscellaneous	Computer Services	143
Odessian LLC	Computer Services	72
CCH	Computer Services	21
Lexis-Nexis	Computer Services	8
Ipanema Solutions	Computer Services	19
Macquarie Technology Services	Computer Services	130
Advanced Answers on Demand	Computer Services	6749
TeamViewer	Computer Services	22
Stratus Networks	Computer Services	544
Kemper Technology	Computer Services	420
AT&T	Computer Services	7
Medifax	Computer Services	61
Vision Share/Ability Network	Computer Services	924
Barracuda	Computer Services	167
CIAN	Computer Services	222
Comcast	Computer Services	49
Emdeon	Computer Services	74
Marotta Gund Budd & Dzera	Other Prof Fees	2066
David Budde	Other Prof Fees	43
Pharmacy Price Mangement	Other Prof Fees	171
All Scripts	Other Prof Fees	304

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

93,165

Period Beginning 1/1/2013
 Period End 12/31/2013

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Moultrie County Circuit Clerk	150.00	100%	150
Moultrie County Sheriff	46.00	100%	46
Sorling Northrup	462.00	100%	462
Sorling Northrup	252.00	100%	252
Sorling Northrup	1,218.00	100%	1,218
Sorling Northrup	2,310.00	100%	2,310
Sorling Northrup	210.00	100%	210
Sorling Northrup	3,345.95	100%	3,346
Sorling Northrup	42.00	100%	42
Moultrie County Circuit Clerk	5.00	100%	5
Moultrie County Sheriff	23.00	100%	23
Sorling Northrup	2,537.00	100%	2,537
Sorling Northrup	3,486.00	100%	3,486
Sorling Northrup	441.00	100%	441

Home Office Allocation

SmithAmundsen	38549	2.36%	911
Cole, Schotz, Meisel	21229	2.36%	502
Black, Hedin, Ballard	1919	2.36%	45

Total Legal Fees

15,986

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Mason Point# 0050294

Report Period Beginning:

1/1/2013

Ending:

12/31/2013**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,037 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 275,785
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. \$ 10,642
- (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. \$ 82,783
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Mason Point
 0010249
 Period Beginning
 Period End

1/1/2013
 12/31/2013

Independent Living Offset

Schedule 23A

Census Days Summary:

Days	%
17,784	32.52%
36,909	67.48%
<u>54,693</u>	<u>100.00%</u>

Independent Living
 Nursing Home

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	417,706	32.52%	135,838	Census	1
Food	301,268	32.52%	97,972	Census	2
Housekeeping	209,935	32.52%	68,271	Census	3
Laundry	142,960	32.52%	46,491	Census	4
Utilities	668,197	32.52%	217,298	Census	5
Maintenance	335,621	32.52%	109,144	Census	6
Depreciation (Building)	<u>36,863</u>	100.00%	<u>36,863</u>	Beds	30
Total	<u><u>2,112,550</u></u>		<u><u>711,877</u></u>		

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.