

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2005  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2005)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p><b>I.</b></p> <p>Facility Name: <u>Manor At Mason Woods LP</u></p> <p>Address: <u>205 Illinois Street</u> <u>Pinckneyville</u> <u>62274</u>  <small>Number City Zip Code</small></p> <p>County: <u>Perry County</u></p> <p>Telephone Number: ( <u>618</u> ) <u>357-9770</u> Fax # <u>618 357-9774</u></p> <p>Federal Employer ID Number: <u>37-1406394</u></p> <p>Date Current Owners were Certified: <u>051704</u></p> <p>Type of Ownership:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input checked="" type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact:  Name: <u>Deborah J Edwards</u> Telephone Number: ( <u>618</u> ) <u>233-1001</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input checked="" type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01-01-05</u> to <u>12-31-05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%"> <tr> <td style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> <td>(Date) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u> (Firm Name &amp; Address) <u>Creason-Edwards &amp; Cimarolli, PC</u> <u>4000 N Belt West Belleville, IL 62226</u> (Telephone) <u>618 233-1001</u> Fax <u>618-233-6009</u></td> <td>(Date) _____</td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE  IL DEPT OF HEALTHCARE AND FAMILY SERVICES  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	(Date) _____	Paid Preparer	(Signed) _____ (Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u> (Firm Name & Address) <u>Creason-Edwards &amp; Cimarolli, PC</u> <u>4000 N Belt West Belleville, IL 62226</u> (Telephone) <u>618 233-1001</u> Fax <u>618-233-6009</u>	(Date) _____
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Facility Name Manor At Mason Woods LP

Report Period Beginning: 01-01-05 Ending: 12-31-05

**III. STATISTICAL DATA**

**A. Certified units; enter number of units and unit days**

Date of change in certified units 9/01/2005

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	24	Single Unit Apartment	30	9,492	1
2	6	Double Unit Apartment	10	2,678	2
3		Other		230	3
4	30	TOTALS	40	12,400	4

**B. Census-For the entire report period.**

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	6,182	2,684		8,866	5
6	Double Unit	1,034	1,540		2,574	6
7	Other					7
8	TOTALS	7,216	4,224		11,440	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 92.26%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 188 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 11 (Do not include bed-hold days in Section B.)

**E. Does page 3 include expenses for services or investments not directly related to SLF services?**

YES  NO

**F. Does the BALANCE SHEET reflect any non-SLF assets?**

YES  NO

**G. List all services provided by your facility for non-residents.**  
(E.g., day care, "meals on wheels", outpatient therapy)

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**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

**I. Is your fiscal year identical to your tax year?**  YES  NO

Tax Year: 2005 Fiscal Year: \_\_\_\_\_

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

**J. Does the facility have any Illinois Housing Development Authority Loans outstanding?** YES If yes, did the facility make all of the required payments of interest and principle? YES

If no, explain. \_\_\_\_\_

**K. Does the facility have any loans from the Federal Home Loan Bank outstanding?** NO If yes, did the facility make all of the required payments of interest and principle? \_\_\_\_\_

If no, explain. \_\_\_\_\_

**L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding?** NO If yes, did the facility make all of the required payments of interest and principle? \_\_\_\_\_

If no, explain. \_\_\_\_\_

Facility Name: Manor At Mason Woods LP

Report Period Beginning:

01-01-05

Ending:

12-31-05

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	52,593	57,509	1,630	111,732	(70)	111,662	1
2	Housekeeping, Laundry and Maintenance	33,848	8,749	10,181	52,778		52,778	2
3	Heat and Other Utilities			26,128	26,128	(1,974)	24,154	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>86,441</b>	<b>66,258</b>	<b>37,939</b>	<b>190,638</b>	<b>(2,044)</b>	<b>188,594</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	145,379	6,686	3,118	155,183		155,183	6
7	Activities and Social Services	18,525	1,881	161	20,567		20,567	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>163,904</b>	<b>8,567</b>	<b>3,279</b>	<b>175,750</b>		<b>175,750</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	55,581	7,162	65,652	128,395		128,395	10
11	Marketing Materials, Promotions and Advertising		2,713	12,059	14,772		14,772	11
12	Employee Benefits and Payroll Taxes			56,941	56,941		56,941	12
13	Insurance-Property, Liability and Malpractice			26,480	26,480		26,480	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>55,581</b>	<b>9,875</b>	<b>161,132</b>	<b>226,588</b>		<b>226,588</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>305,926</b>	<b>84,700</b>	<b>202,350</b>	<b>592,976</b>	<b>(2,044)</b>	<b>590,932</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			89,777	89,777		89,777	17
18	Interest			47,540	47,540		47,540	18
19	Real Estate Taxes			19,227	19,227		19,227	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			2,509	2,509		2,509	21
22	Other (specify):Development Fee			20,045	20,045		20,045	22
23	<b>TOTAL Ownership</b>			<b>179,098</b>	<b>179,098</b>		<b>179,098</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>305,926</b>	<b>84,700</b>	<b>381,448</b>	<b>772,074</b>	<b>(2,044)</b>	<b>770,030</b>	<b>24</b>

Facility Name: Manor At Mason Woods LP

Report Period Beginning: 01-01-05 Ending: 12-31-05

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

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses		\$	1
2	Licensed Practical Nurses	1	11.37	2
3	Certified Nurse Assistants	6	8.36	3
4	Activity Director & Assistants	1	8.94	4
5	Social Service Workers			5
6	Head Cook	1	10.00	6
7	Cook Helpers/Assistants	2	7.94	7
8	Dishwashers			8
9	Maintenance Workers	1	8.36	9
10	Housekeepers	1	7.80	10
11	Laundry			11
12	Managers	2	14.04	12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>15</b>	<b>\$ 9.37</b>	<b>17</b>

**VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.**

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2					2
3					3
4					4
5					5
<b>Total</b>				<b>\$</b>	<b>6</b>

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$ 3</b>

**VII. RELATED ORGANIZATIONS**

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

**RELATED SLF's & HEALTH CARE BUSINESSES**

Name <u>1</u>	City <u>2</u>
The Prairie's	Carbondale
O'Fallon Healthcare Center, Inc	O'Fallon
St. Ann's	Chester
Clinton Manor	New Baden

**OTHER RELATED BUSINESS ENTITIES**

Name <u>3</u>	City <u>4</u>	Type of Business <u>5</u>
Greer Management Services Inc	Caryle	Management Compa

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES  NO

Name of related entity: \_\_\_\_\_ If yes, what is the value of those services? \$ \_\_\_\_\_

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES  NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup). Management Fees of \$35,941

Facility Name: Manor At Mason Woods LP

Report Period Beginning:

01-01-05

Ending:

12-31-05

VIII. OWNERSHIP COSTS

A. Purchase price of land 27,947 Year land was acquired 2004

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

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

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	40		2004	2004	\$ 1,879,570	\$ 68,348	28	\$ 68,348	\$	\$ 108,218	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Door Opener		2004	2004	3,128	114	28	114		123	6
7	Hand Rails		2005	2005	2,382	58	28	58		58	7
8	Automatic Door Opener		2005	2005	3,362	41	28	41		41	8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 1,888,442	\$ 68,561		\$ 68,561	\$	\$ 108,440	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 58,437	\$ 10,094	\$ 10,094	\$	5	\$ 15,190	18
19	Vehicles	25,386	4,444	4,444		5	5,926	19
20	TOTAL (lines 18 and 19)		\$ 83,823	\$ 14,538	\$ 14,538		\$ 21,116	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)		\$	\$	24

Facility Name: Manor At Mason Woods LP

Report Period Beginning: 01-01-05

Ending: 12-31-05

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

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?  YES  NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	<b>TOTAL</b>				\$			7

8. Is movable equipment rental included in building rental?  YES  NO

9. Rental amount for movable equipment \$ 1,846

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

**X. INTEREST EXPENSE**

	1	2		3	4	6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	<b>A. Directly Facility Related Long-Term</b>										
1	Murphy-Wall State Bank	X		Mortgage	6/30/03	\$ 490,000	\$ 469,196	6/30/23	6.9200	\$ 36,848	1
2	IL Hsg Development Auth		X	Mortgage	6/30/03	750,000	732,420	1/1/25	1.0000	7,420	2
3	See Supplemental Sch					22,450	14,945			813	3
	<b>Working Capital</b>										
4	Murphy-Wall State Bank	X		Line of Credit	10/3/05	100,000	50,000	10/3/06	6.5000	2,459	4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 1,362,450	\$ 1,266,561			\$ 47,540	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 1,362,450	\$ 1,266,561			\$ 47,540	10

\* If there is an option to buy the building, please provide complete details on an attached schedule.

\*\* If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

## STATE OF ILLINOIS

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Facility Name: Manor At Mason Woods LP

Report Period Beginning: 01-01-05

Ending:

12-31-05

12-31-05

## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-05

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 48,181	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	168,225		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,423		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 219,829	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,947		13
14	Buildings, at Historical Cost	1,879,570		14
15	Leasehold Improvements, at Historical Cost	8,872		15
16	Equipment, at Historical Cost	83,823		16
17	Accumulated Depreciation (book methods)	(129,556)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	80,752		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(18,394)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,933,014	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,152,843	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,700	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,367		28
29	Short-Term Notes Payable	138,185		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable	7,127		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	Deferred Revenue	13,758		35
36	Other Accrued Liabilities	25,941		36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 189,078	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	7,453		38
39	Mortgage Payable	1,170,922		39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 1,178,375	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 1,367,453	\$	45
46	<b>TOTAL EQUITY</b>	\$ 785,390	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 2,152,843	\$	47

\*(See instructions.)

Facility Name: Manor At Mason Woods LP

Report Period Beginning: 01-01-05

Ending:

12-31-05

**XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)**

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 746,704	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 746,704	3
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals	70	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 70	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income		13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)		14
<b>D. Other Revenue (specify):</b>			
15			15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)		17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 746,774	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	190,638	19
20	Health Care/ Personal Care	175,750	20
21	General Administration	226,588	21
<b>B. Capital Expense</b>			
22	Ownership	179,098	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 772,074	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ (25,300)	29
30	<b>Income Taxes</b>		30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ (25,300)	31

**IV. COST CENTER EXPENSES, COLUMN 5 - RECLASSIFICATIONS AND ADJUSTMENTS**

Line 1 Dietary and Food Purchase: Guest Meals \$70

Line 3 Heat and Other Utilities: Cable in Residents Roc \$1,974

**X. INTEREST EXPENSE**

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Int. Expense	
		YES	NO			Original	Balance				
		A. Directly Facility Related Long-Term									
1	FNB Of St. Louis		X	Vehicle	8/4/04	\$ 14,850	\$ 8,504	8/15/07	4.9900	\$ 555	1
2	Village Bank		X	Vehicle	6/2/05	7,600	6,441	6/30/08	7.2500	258	2
3	Page Total					22,450	14,945			813	3