

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2006  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2006)**

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>The Manor At Mason Woods</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>618-357-9770</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>05/17/04</u></p> <p>Type of Ownership:</p> <table border="0"> <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> 233-1001</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>01-01-06</u> to <u>12-31-06</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 border="1"> <tr> <td rowspan="2" style="width: 20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>J Michael Greer</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Partner</u></td> <td></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Deborah J Edwards</u> <u>CPA</u></td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Creason-Edwards &amp; Cimarolli, PC</u> <u>4000 N Belt West Belleville, IL 62226</u></td> <td></td> </tr> <tr> <td>(Telephone) <u>618-233-1001</u> Fax <u>618-233-1001</u></td> <td></td> </tr> </table> <p align="center">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) _____	(Date) _____	(Type or Print Name) <u>J Michael Greer</u>			(Title) <u>Partner</u>		Paid Preparer	(Signed) _____	(Date) _____	(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>618-233-1001</u>	
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Facility Name: The Manor At Mason Woods

Report Period Beginning:

01-01-06

Ending:

12-31-06

## 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	62,659	79,692	1,535	143,886	(622)	143,264	1
2	Housekeeping, Laundry and Maintenance	70,718	8,387	8,173	87,278		87,278	2
3	Heat and Other Utilities			38,664	38,664	(1,734)	36,930	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	133,377	88,079	48,372	269,828	(2,356)	267,472	5
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	171,892	6,078	7,521	185,491		185,491	6
7	Activities and Social Services	19,701	2,822	405	22,928		22,928	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	191,593	8,900	7,926	208,419		208,419	9
<b>C. General Administration</b>								
10	Administrative and Clerical	55,065	3,176	65,764	124,005		124,005	10
11	Marketing Materials, Promotions and Advertising		3,716	14,802	18,518		18,518	11
12	Employee Benefits and Payroll Taxes		63,141		63,141		63,141	12
13	Insurance-Property, Liability and Malpractice		26,500		26,500		26,500	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	55,065	96,533	80,566	232,164		232,164	15
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	380,035	193,512	136,864	710,411	(2,356)	708,055	16
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			98,290	98,290		98,290	17
18	Interest			86,651	86,651		86,651	18
19	Real Estate Taxes			55,500	55,500		55,500	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			2,526	2,526		2,526	21
22	Other (specify): Amortization Expense			1,233	1,233		1,233	22
23	<b>TOTAL Ownership</b>			244,200	244,200		244,200	23
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	380,035	193,512	381,064	954,611	(2,356)	952,255	24

Facility Name: The Manor At Mason Woods

Report Period Beginning: 01-01-06 Ending: 12-31-06

**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	11.19	2
3	Certified Nurse Assistants	7	8.44	3
4	Activity Director & Assistants	1	9.33	4
5	Social Service Workers			5
6	Head Cook	1	8.41	6
7	Cook Helpers/Assistants	2	7.99	7
8	Dishwashers			8
9	Maintenance Workers	1	10.41	9
10	Housekeepers	1	8.44	10
11	Laundry			11
12	Managers	2	12.32	12
13	Other Administrative	2	12.11	13
14	Clerical			14
15	Marketing			15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>18</b>	<b>\$ 9.54</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	Carlyle	Management Co

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 \$37,366

Facility Name: The Manor At Mason Woods

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01-01-06

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12-31-06

VIII. OWNERSHIP COSTS

A. Purchase price of land \_\_\_\_\_ Year land was acquired \_\_\_\_\_

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	30		2004	2004	\$ 1,879,570	\$ 68,348	28	\$ 68,348	\$	\$ 176,566	1
2	10		2006	2006	520,000	12,778	28	12,778		12,778	2
3											3
4											4
5											5
Improvement Type											
6		Door Opener		2004	3,128	114	28	114		237	6
7		Hand Rails		2005	2,382	87	28	87		144	7
8		Automatic Door Opener		2005	3,362	122	28	122		163	8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 2,408,442	\$ 81,449		\$ 81,449	\$	\$ 189,888	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	\$ 63,037	\$ 11,764	\$ 11,764	\$	5	\$ 26,954	18
19	Vehicles	25,386	5,077	5,077		5	11,003	19
20	TOTAL (lines 18 and 19)		\$ 88,423	\$ 16,841	\$ 16,841		\$ 37,957	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

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**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 \$ 2,526

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	\$ 454,773	6/30/23	6.9200	\$ 32,017	1
2	IL Hsg Development Auth		X	Mortgage	6/30/03	750,000	714,663	1/1/25	1.0000	7,243	2
3	See Supplemental Sch				/ /	692,450	673,615	/ /		45,527	3
	<b>Working Capital</b>										
4	Murphy-Wall State Bank	X		Line of Credit	10/3/05	100,000		/ /	6.5000	1,864	4
5					/ /			/ /			5
6					/ /			/ /			6
7	<b>TOTAL Facility Related</b>					\$ 2,032,450	\$ 1,843,051			\$ 86,651	7
	<b>B. Non-Facility Related</b>										
8					/ /			/ /			8
9					/ /			/ /			9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$ 2,032,450	\$ 1,843,051			\$ 86,651	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: The Manor At Mason Woods

Report Period Beginning: 01-01-06

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## XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-06

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 250,260	\$	1
2	Cash-Patient Deposits	1,139		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	138,791		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,807		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>	\$ 402,997	\$	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	2,399,570		14
15	Leasehold Improvements, at Historical Cost	8,872		15
16	Equipment, at Historical Cost	88,423		16
17	Accumulated Depreciation (book methods)	(227,845)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	80,752		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(19,627)		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>	\$ 2,358,092	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,761,089	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 4,345	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,001		28
29	Short-Term Notes Payable	43,569		29
30	Accrued Salaries Payable	12,189		30
31	Accrued Taxes Payable	5,342		31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35	<b>Other Accrued Liabilities</b>	36,587		35
36				36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 103,033	\$	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	1,361		38
39	Mortgage Payable	1,798,120		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>	\$ 1,799,481	\$	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 1,902,514	\$	45
46	<b>TOTAL EQUITY</b>	\$ 858,575	\$	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 2,761,089	\$	47

\*(See instructions.)

Facility Name: The Manor At Mason Woods

Report Period Beginning: 01-01-06

Ending:

12-31-06

**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	\$ 1,025,397	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 1,025,397	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	473	8
9	Non-Resident Meals	622	9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$ 1,095	11
<b>C. Non-Operating Revenue</b>			
12	Contributions	340	12
13	Interest and Other Investment Income	963	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 1,303	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)	\$ 1,027,795	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	269,828	19
20	Health Care/ Personal Care	208,419	20
21	General Administration	232,164	21
<b>B. Capital Expense</b>			
22	Ownership	244,200	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)	\$ 954,611	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ 73,184	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ 73,184	31

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				
	A. Directly Facility Related Long-Term										
1	FNB Of St. Louis		X	Vehicle	8/4/04	\$ 14,850	\$ 3,460	8/15/07	4.9900	\$ 310	1
2	Village Bank		X	Vehicle	6/2/05	7,600	3,781	6/30/08	7.2500	411	2
3	Murphy-Wall State Bank	X		Construction Loan	1/1/06	520,000	520,000		7.7500	37,134	3
4	Murphy-Wall State Bank	X		Mortgage	4/26/06	150,000	146,374	4/26/09	7.7500	7,672	4
5	Page Total					692,450	673,615			45,527	5