

		FOR BHF USE			

LL2

Supportive Living Facility

**2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2007)**

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>I.</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</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>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>) <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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01-01-07</u> to <u>12-31-07</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 & Address) <u>Creason-Edwards & 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>618-233-6009</u></td> <td></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) _____	(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 & Cimarolli PC</u> <u>4000 N Belt West Belleville, IL 62226</u>		(Telephone) <u>618 233-1001</u> Fax <u>618-233-6009</u>	
<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 _____																																									
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 & Cimarolli PC</u> <u>4000 N Belt West Belleville, IL 62226</u>																																									
	(Telephone) <u>618 233-1001</u> Fax <u>618-233-6009</u>																																									

Facility Name: The Manor at Mason Woods

Report Period Beginning:

01-01-07

Ending:

12-31-07

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			
A. General Services								
1	Dietary and Food Purchase		79,971	76,780	156,751	(446)	156,305	1
2	Housekeeping, Laundry and Maintenance		12,890	91,485	104,375		104,375	2
3	Heat and Other Utilities			47,180	47,180	(1,757)	45,423	3
4	Other (specify):							4
5	TOTAL General Services		92,861	215,445	308,306	(2,203)	306,103	5
B. Health Care and Programs								
6	Health Care/ Personal Care		3,131	196,323	199,454		199,454	6
7	Activities and Social Services		4,141	23,397	27,538		27,538	7
8	Other (specify):							8
9	TOTAL Health Care and Programs		7,272	219,720	226,992		226,992	9
C. General Administration								
10	Administrative and Clerical		6,216	150,273	156,489		156,489	10
11	Marketing Materials, Promotions and Advertising		7,056	7,500	14,556		14,556	11
12	Employee Benefits and Payroll Taxes							12
13	Insurance-Property, Liability and Malpractice			25,858	25,858		25,858	13
14	Other (specify):							14
15	TOTAL General Administration		13,272	183,631	196,903		196,903	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)		113,405	618,797	732,202	(2,203)	729,999	16
Capital Expenses								
D. Ownership								
17	Depreciation			102,949	102,949		102,949	17
18	Interest			90,006	90,006		90,006	18
19	Real Estate Taxes			52,929	52,929		52,929	19
20	Rent -- Facility and Grounds							20
21	Rent -- Equipment			1,207	1,207		1,207	21
22	Other (specify): Replacement Tax			702	702		702	22
23	TOTAL Ownership			247,793	247,793		247,793	23
24	GRAND TOTAL (Sum of lines 16 and 23)		113,405	866,590	979,995	(2,203)	977,792	24

Facility Name: The Manor at Mason Woods

Report Period Beginning: 01-01-07 Ending: 12-31-07

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			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants			4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants			7
8	Dishwashers			8
9	Maintenance Workers			9
10	Housekeepers			10
11	Laundry			11
12	Managers			12
13	Other Administrative			13
14	Clerical			14
15	Marketing			15
16	Other			16
17	Total (lines 1 thru 16)		\$	17

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
Total				\$	6

VI. (B) Management fees paid to unrelated parties

	Amount of Fee	
1	\$	1
2		2
Total		\$ 3

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	City
<u>1</u> The Prairie's	<u>2</u> Carbondale
St. Ann's Healthcare	Chester
Clinton Manor Nursing Home	New Baden
The Manor at Craig Farms	Chester

OTHER RELATED BUSINESS ENTITIES

Name	City	Type of Business
<u>3</u> Greer Management Services	<u>4</u> Carlyle	<u>5</u> Management Co
JMG, LLC	Carlyle	Staffing Svc

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).

Attachments1

Facility Name: The Manor at Mason Woods

Report Period Beginning: 01-01-07

Ending: 12-31-07

VIII. OWNERSHIP COSTS

A. Purchase price of land 27,947 Year land was acquired 2003

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	\$	\$ 244,914	1
2	10		2006	2006	520,000	13,333	28	13,333		26,111	2
3											3
4											4
5											5
Improvement Type											
6		Door Opener		2004	3,128	114	28	114		351	6
7		Hand Rails		2005	2,382	87	28	87		231	7
8		Automatic Door Opener		2005	3,362	122	28	122		285	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	\$ 82,004		\$ 82,004	\$	\$ 271,892	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	\$ 78,750	\$ 14,635	\$ 14,635	\$	5	\$ 41,589	18
19	Vehicles	25,386	5,077	5,077		5	16,080	19
20	TOTAL (lines 18 and 19)	\$ 104,136	\$ 19,712	\$ 19,712	\$		\$ 57,669	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		\$	\$	\$	#
22					#
23					#
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	#

Facility Name: The Manor at Mason Woods

Report Period Beginning: 01-01-07

Ending: 12-31-07

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	TOTAL				\$			7

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

9. Rental amount for movable equipment \$ 1,207

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				
	A. Directly Facility Related Long-Term										
1	Murphy-Wall State Bank	X		Mortgage	6/30/03	\$ 490,000	\$ 439,320	6/30/23	6.9200	\$ 30,973	1
2	IL Hsg Development Auth		X	Mortgage	6/30/03	750,000	696,727	1/1/25	1.0000	7,065	2
3	See Supplemental Sch				/ /	692,450	661,932	/ /		51,968	3
	Working Capital										
4								/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$ 1,932,450	\$ 1,797,979			\$ 90,006	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$ 1,932,450	\$ 1,797,979			\$ 90,006	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

Facility Name: The Manor at Mason Woods

Report Period Beginning: 01-01-07

Ending:

12-31-07

12-31-07

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12-31-07

(last day of reporting year)

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 460,341	\$	1
2	Cash-Patient Deposits	1,821		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	124,358		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,773		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	3,667		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 598,960	\$	10
B. Long-Term Assets				
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	104,136		16
17	Accumulated Depreciation (book methods)	(329,562)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	80,752		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(20,860)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,270,855	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,869,815	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 29,015	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	42,302		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
Other Current Liabilities(specify):				
35	Other Accrued Liabilities	73,387		35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 144,704	\$	37
D. Long-Term Liabilities				
38	Long-Term Notes Payable			38
39	Mortgage Payable	1,755,678		39
40	Bonds Payable			40
41	Deferred Compensation			41
Other Long-Term Liabilities(specify):				
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$ 1,755,678	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 1,900,382	\$	45
46	TOTAL EQUITY	\$ 969,433	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 2,869,815	\$	47

*(See instructions.)

Facility Name: The Manor at Mason Woods

Report Period Beginning: 01-01-07

Ending:

12-31-07

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

	1	Amount	
	Revenue		
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,086,619	1
2	Discounts and Allowances		2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,086,619	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop	198	7
8	Barber and Beauty Care	622	8
9	Non-Resident Meals	446	9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 1,266	11
	C. Non-Operating Revenue		
12	Contributions	222	12
13	Interest and Other Investment Income	2,746	13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$ 2,968	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,090,853	18

	2	Amount	
	Expenses		
	A. Operating Expenses		
19	General Services	308,306	19
20	Health Care/ Personal Care	226,992	20
21	General Administration	196,903	21
	B. Capital Expense		
22	Ownership		22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 732,201	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 358,652	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 358,652	31

VII: RELATED ORGANIZATIONS

	Related Organization	Nature of Expenditure	Facility Book Value	Actual Cost
C.	Greer Management Services, Inc.	Management Services	\$ 46,849	\$ 70,520
	JMG II, LLC	Staffing Services	\$ 427,524	\$ 428,084