

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0025411

Facility Name: Mulberry Manor

Address: 612 East Davie Street, Box 88 Anna 62906
 Number City Zip Code

County: Union

Telephone Number: (618) 833-6012 **Fax #** (618) 833-4993

HFS ID Number: _____

Date of Initial License for Current Owners: 01/01/1972

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input 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 type="checkbox"/>	Partnership	<input type="checkbox"/>	County
<input type="checkbox"/>	IRS Exemption Code _____	<input checked="" 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 _____		

In the event there are further questions about this report, please contact:
Name: Ashley Alley **Telephone Number:** (618) 833-5070 x11
Email Address: _____

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2012 to 12/31/2012 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
 (Signed) _____ (Date) _____
 (Type or Print Name) Ashley Alley
 (Title) Asst. Comptroller

Paid Preparer
 (Signed) _____ (Date) _____
 (Print Name and Title) _____
 (Firm Name & Address) _____
 (Telephone) () () Fax # () ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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 23,424

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>64</u>	ICF/DD 16 or Less	<u>64</u>	<u>23,424</u>	6
7	<u>64</u>	TOTALS	<u>64</u>	<u>23,424</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	<u>22,532</u>			<u>22,532</u>	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,532</u>			<u>22,532</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.19%

D. How many bed-hold days during this year were paid by the Department?

52 (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 01/01/1972

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	118,351	5,440	5,940	129,731		129,731		129,731		1
2	Food Purchase		183,287		183,287		183,287		183,287		2
3	Housekeeping	36,203	17,349	100	53,652		53,652	225	53,877		3
4	Laundry		10,994	60	11,054		11,054		11,054		4
5	Heat and Other Utilities			59,267	59,267		59,267	784	60,051		5
6	Maintenance	41,588	20,309	6,223	68,120		68,120	22,276	90,396		6
7	Other (specify):*										7
8	TOTAL General Services	196,142	237,379	71,590	505,111		505,111	23,285	528,396		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	804,787	20,973	7,748	833,508		833,508	4,413	837,921		10
10a	Therapy		2,279	15,370	17,649		17,649		17,649		10a
11	Activities	25,176		266	25,442		25,442		25,442		11
12	Social Services		4,410	9,490	13,900		13,900	(1,408)	12,492		12
13	CNA Training	6,316		1,225	7,541		7,541		7,541		13
14	Program Transportation		15,107	7,364	22,471		22,471	3,278	25,749		14
15	Other (specify):* Day Training			868,281	868,281		868,281	(868,281)			15
16	TOTAL Health Care and Programs	836,279	42,769	916,944	1,795,992		1,795,992	(861,998)	933,994		16
	C. General Administration										
17	Administrative	115,328			115,328		115,328	21,050	136,378		17
18	Directors Fees			1,500	1,500		1,500		1,500		18
19	Professional Services			104,405	104,405		104,405	(101,704)	2,701		19
20	Dues, Fees, Subscriptions & Promotions			6,346	6,346		6,346	(3,147)	3,199		20
21	Clerical & General Office Expenses	31,644	9,131	13,173	53,948		53,948	32,179	86,127		21
22	Employee Benefits & Payroll Taxes			164,205	164,205		164,205	12,522	176,727		22
23	Inservice Training & Education			925	925		925		925		23
24	Travel and Seminar							30	30		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			8,074	8,074		8,074	660	8,734		26
27	Other (specify):* Finance Charge			76	76		76	(76)			27
28	TOTAL General Administration	146,972	9,131	298,704	454,807		454,807	(38,486)	416,321		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,179,393	289,279	1,287,238	2,755,910		2,755,910	(877,199)	1,878,711		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

Mulberry Manor

#0025411

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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			89,761	89,761		89,761	(60,648)	29,113			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,554	3,554		3,554	(1,337)	2,217			32
33	Real Estate Taxes			30,329	30,329		30,329	628	30,957			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(237,856)	2,144			34
35	Rent-Equipment & Vehicles			2,774	2,774		2,774	148	2,922			35
36	Other (specify):* See Pg. 24			(266,837)	(266,837)		(266,837)	266,837				36
37	TOTAL Ownership			99,581	99,581		99,581	(32,228)	67,353			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			150,014	150,014		150,014		150,014			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			150,014	150,014		150,014		150,014			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,179,393	289,279	1,536,833	3,005,505		3,005,505	(909,427)	2,096,078			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 Mulberry Manor

0025411

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

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	\$ (868,281)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(67)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(59,247)	30		9
10	Interest and Other Investment Income	(1,337)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(76)	27		18
19	Entertainment				19
20	Contributions	50	20		20
21	Owner or Key-Man Insurance	(246)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(212)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	12,300	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See 5A	247,748			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (669,368)		\$	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)	(240,059)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (240,059)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (909,427)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Mulberry Manor

ID# 0025411

Report Period Beginning: 01/01/2012

Ending: 12/31/2012

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Federal Income Tax	\$ 254,783	36	1
2	Floral	(318)	12	2
3	Gifts to Clients	(1,084)	12	3
4	Tobacco	(6)	12	4
5	IDPH Fine	(3,250)	20	5
6	Non-Care Asset: Rental Property Depreciation	(2,377)	30	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
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	247,748		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	225	0	0	0	0	0	0	0	0	0	225	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	784	0	0	0	0	0	0	0	0	0	784	5
6	Maintenance	0	467	21,809	0	0	0	0	0	0	0	0	22,276	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,476	21,809	0	0	0	0	0	0	0	0	23,285	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	0	4,413	0	0	0	0	0	0	0	0	4,413	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(1,408)	0	0	0	0	0	0	0	0	0	0	(1,408)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	3,278	0	0	0	0	0	0	0	0	0	3,278	14
15	Other (specify):*	(868,281)	0	0	0	0	0	0	0	0	0	0	(868,281)	15
16	TOTAL Health Care and Programs	(869,689)	3,278	4,413	0	0	0	0	0	0	0	0	(861,998)	16
	C. General Administration													
17	Administrative	0	0	21,050	0	0	0	0	0	0	0	0	21,050	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	296	(102,000)	0	0	0	0	0	0	0	0	(101,704)	19
20	Fees, Subscriptions & Promotions	(3,412)	265	0	0	0	0	0	0	0	0	0	(3,147)	20
21	Clerical & General Office Expenses	0	3,852	28,327	0	0	0	0	0	0	0	0	32,179	21
22	Employee Benefits & Payroll Taxes	(67)	12,589	0	0	0	0	0	0	0	0	0	12,522	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	30	0	0	0	0	0	0	0	0	0	30	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	660	0	0	0	0	0	0	0	0	0	660	26
27	Other (specify):*	(76)	0	0	0	0	0	0	0	0	0	0	(76)	27
28	TOTAL General Administration	(3,555)	17,692	(52,623)	0	0	0	0	0	0	0	0	(38,486)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(873,244)	22,446	(26,401)	0	0	0	0	0	0	0	0	(877,199)	29

STATE OF ILLINOIS

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

01/01/2012 Ending:

Summary B

12/31/2012

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	(61,624)	976	0	0	0	0	0	0	0	0	0	(60,648)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,337)	0	0	0	0	0	0	0	0	0	0	(1,337)	32
33	Real Estate Taxes	0	628	0	0	0	0	0	0	0	0	0	628	33
34	Rent-Facility & Grounds	0	2,144	(240,000)	0	0	0	0	0	0	0	0	(237,856)	34
35	Rent-Equipment & Vehicles	0	0	148	0	0	0	0	0	0	0	0	148	35
36	Other (specify):*	266,837	0	0	0	0	0	0	0	0	0	0	266,837	36
37	TOTAL Ownership	203,876	3,748	(239,852)	0	0	0	0	0	0	0	0	(32,228)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(669,368)	26,194	(266,253)	0	0	0	0	0	0	0	0	(909,427)	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
JoAnn Keller	50	Pilot House	Cairo	kel-Tech Mgmt. Co.	Anna	Mgmt. Services
James K. Keller Family Trust	50	Lincoln Square	Jonesboro	JR's Center	Anna	Workshop
		Glen Brook	Vienna	ILS 1-3 & 5-6	Anna	CILA
		Krypton	Metropolis	ILS 4	Metropolis	CILA
		New Way	Anna	ILS Land Trust	Anna	Land Trust
				CIL	Anna	CILA

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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
		Item								
1	V	3	Houskeeping	\$	kel-Tech Management Co.	25.00%	\$ 225	\$	225	1
2	V	5	Heat & Other Utilities		kel-Tech Management Co.	25.00%	784		784	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	467		467	3
4	V	14	Program Transportation		kel-Tech Management Co.	25.00%	3,278		3,278	4
5	V	19	Professional Services		kel-Tech Management Co.	25.00%	296		296	5
6	V	20	Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	265		265	6
7	V	21	Clerical & General		kel-Tech Management Co.	25.00%	3,852		3,852	7
8	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	12,589		12,589	8
9	V	24	Inservice Trn'g & Education		kel-Tech Management Co.	25.00%	30		30	9
10	V	26	Insurance		kel-Tech Management Co.	25.00%	660		660	10
11	V	30	Depreciation		kel-Tech Management Co.	25.00%	976		976	11
12	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	628		628	12
13	V	34	Rent- Facility		kel-Tech Management Co.	25.00%	2,144		2,144	13
14	Total			\$			\$ 26,194	\$ *	26,194	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	35 Rent - Equipment	\$	kel-Tech Management Co.		\$ 148	\$ 148
16	V	10 Nursing		kel-Tech Management Co.		4,413	4,413
17	V	17 Administration		kel-Tech Management Co.		21,050	21,050
18	V	21 Clerical		kel-Tech Management Co.		28,327	28,327
19	V	6 Maintenance		kel-Tech Management Co.		21,809	21,809
20	V						
21	V						
22	V	19 Professional Services	102,000	kel-Tech Management Co.	25.00%		(102,000)
23	V	34 Building Lease	240,000	J & J Partners	100.00%		(240,000)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 342,000			\$ 75,747	\$ * (266,253)

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

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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								1
2	Don Pippins	50	New Way	Anna				2
3	Denise Pippins	50	New Way	Anna				3
4	Jacob L. Alley	50	Lincoln Square	Jonesboro				4
5	Diana Alley	50	Lincoln Square	Jonesboro				5
6	Jacob L. Alley	50	Krypton	Metropolis				6
7	Diana Alley	50	Krypton	Metropolis				7
8	James A. Keller	50	Glen Brook	Vienna				8
9	Norine Keller	50	Glen Brook	Vienna				9
10	JoAnn Keller	50	Mulberry Manor	Anna				10
11	James K. Keller Family Trust	50	Mulberry Manor	Anna				11
12	Don Pippins	50			CIL	Anna	CILA	12
13	Denise Pippins	50			CIL	Anna	CILA	13
14	Don Pippins	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	14
15	Jacob L. Alley	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	15
16	James A. Keller	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	16
17	James K. Keller Family Trust	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	17
18	Don Pippins	25			Independent Living Se	Anna	CILA	18
19	Jacob L. Alley	25			Independent Living Se	Anna	CILA	19
20	James A. Keller	25			Independent Living Se	Anna	CILA	20
21	James K. Keller Family Trust	25			Independent Living Se	Anna	CILA	21
22	Don Pippins	25			ILS Land Trust	Anna	Land Trust	22
23	Jacob L. Alley	25			ILS Land Trust	Anna	Land Trust	23
24	James A. Keller	25			ILS Land Trust	Anna	Land Trust	24
25	James K. Keller Family Trust	25			ILS Land Trust	Anna	Land Trust	25
26	JoAnn Keller	25			JR Center	Anna	Workshop	26
27	Don Pippins	25			JR Center	Anna	Workshop	27
28								28
29								29
30								30

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 01/01/2012 Ending: 12/31/2012

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	2	3	4	5	6		7		8	9	
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**				
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference		
1	JoAnn Keller	Owner/Admin	Administrator	50.00	24,000	32	80.00	Admin. Wage	\$ 104,460	17-1	1
2	James K. Keller	Owner	Maintenance	50.00		10	25.00	Maintenance	6,108	6-1	2
3	James A. Keller	Director	Director	0.00	18,000	5	5.00	Director Fee	1,500	18-3	3
4	Diana Alley	QSP		0.00	21,051	9	20.00	Program	1,152	17-1	4
5	Natasha Davis	DSP	DSP	0.00				Program	2,288	10-1	5
6	Ashley Alley	QSP		0.00	500	9	20.00	Program	13,880	17-1	6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	4,413	19-3	8
9	Jacob Alley							Maintenance	16,894	19-3	9
10	James A. Keller							Administration	21,050	19-3	10
11	Ashley Alley							Clerical	11,062	19-3	11
12											12
13								TOTAL	\$ 182,807		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 Mulberry Manor

0025411 Report Period Beginning: 01/01/2012

Ending: 2/31/2012

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 kel-Tech Management Co.
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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	3	Houskeeping	Mgmt Fee Contribution	342,496	8	\$ 756	\$ 102,000	\$ 225	1
2	5	Utilities Elec/Gas	Mgmt Fee Contribution	342,496	8	2,254	102,000	671	2
3	5	Utilities Water	Mgmt Fee Contribution	342,496	8	380	102,000	113	3
4	6	Maint. Building	Mgmt Fee Contribution	342,496	8	93	102,000	28	4
5	6	Maint. Supplies	Mgmt Fee Contribution	342,496	8	293	102,000	87	5
6	6	Repairs Furn/Equip	Mgmt Fee Contribution	342,496	8	181	102,000	54	6
7	6	Grounds Maint.	Mgmt Fee Contribution	342,496	8	50	102,000	15	7
8	6	Contract Services	Mgmt Fee Contribution	342,496	8	950	102,000	283	8
9	14	Repairs Vehicle	Mgmt Fee Contribution	342,496	8	420	102,000	125	9
10	14	Transportation	Mgmt Fee Contribution	342,496	8	6,808	102,000	2,028	10
11	14	Insurance Vehicles	Mgmt Fee Contribution	342,496	8	1,613	102,000	480	11
12	14	Maint. Vehicle	Mgmt Fee Contribution	342,496	8	2,166	102,000	645	12
13	19	Legal & Accounting	Mgmt Fee Contribution	342,496	8	995	102,000	296	13
14	20	Dues Fees Subscriptions	Mgmt Fee Contribution	342,496	8	889	102,000	265	14
15	21	G & A Misc.	Mgmt Fee Contribution	342,496	8	1,044	102,000	311	15
16	21	G & A Misc. Stock	Mgmt Fee Contribution	342,496	8	272	102,000	81	16
17	21	G & A Supplies	Mgmt Fee Contribution	342,496	8	6,570	102,000	1,957	17
18	21	Postage	Mgmt Fee Contribution	342,496	8	1,996	102,000	594	18
19	21	Bank Charges	Mgmt Fee Contribution	342,496	8	61	102,000	18	19
20	21	Telephone	Mgmt Fee Contribution	342,496	8	1,621	102,000	483	20
21	21	Cell Phone	Mgmt Fee Contribution	342,496	8	964	102,000	287	21
22	21	Utilities Internet	Mgmt Fee Contribution	342,496	8	408	102,000	122	22
23	22	Ins Emp Group	Mgmt Fee Contribution	342,496	8	20,144	102,000	5,999	23
24	22	Insurance W/C	Mgmt Fee Contribution	342,496	8	3,115	102,000	928	24
25	TOTALS					\$ 54,043	\$	\$ 16,095	25

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning: 01/01/2012

Ending: 2/31/2012

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 kel-Tech Management Co.
 Street Address 158 E. Vienna Street
 City / State / Zip Code Anna, IL 62906
 Phone Number (618) 833-5070
 Fax Number (618) 833-4993

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	22	Payroll Tax	Mgmt Fee Contribution	342,496	8	\$ 18,946	\$ 102,000	\$ 5,642	1
2	22	Misc Emp Benefits	Mgmt Fee Contribution	342,496	8	65	102,000	19	2
3	24	Adm. Staff Training	Mgmt Fee Contribution	342,496	8	100	102,000	30	3
4	26	Insurance Bldg & Liab.	Mgmt Fee Contribution	342,496	8	2,216	102,000	660	4
5	30	Depreciation	Mgmt Fee Contribution	342,496	8	3,278	102,000	976	5
6	33	Real Estate Taxes	Mgmt Fee Contribution	342,496	8	2,110	102,000	628	6
7	34	Lease Bldg	Mgmt Fee Contribution	342,496	8	7,200	102,000	2,144	7
8	35	Lease Equip	Mgmt Fee Contribution	342,496	8	499	102,000	149	8
9	10	Nursing	Mgmt Fee Contribution	342,496	8	14,820	14,820	4,414	9
10	17	Administration	Mgmt Fee Contribution	342,496	8	70,684	70,684	21,051	10
11	21	Clerical	Mgmt Fee Contribution	342,496	8	95,119	95,119	28,328	11
12	6	Maintenance	Mgmt Fee Contribution	342,496	8	73,235	73,235	21,810	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	TOTALS					\$ 288,272	\$ 253,858	\$ 85,851	25

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

01/01/2012

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12/31/2012

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							\$	\$			\$						
2																	
3																	
4																	
5																	
Working Capital																	
6	Southern Trust	X		Operating Line of Credit		5/2012				6.2500	3,554						
7																	
8																	
9	TOTAL Facility Related						\$	\$			\$ 3,554						
B. Non-Facility Related*																	
10																	
11																	
12																	
13																	
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$	\$			\$ 3,554						

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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2011 report.		\$	30,531	1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	30,329	2
3.	Under or (over) accrual (line 2 minus line 1).		\$	(202)	3
4.	Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,531	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	30,329	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2007	32,515	8		
	2008	31,625	9		
	2009	33,860	10		
	2010	32,100	11		
	2011	30,329	12		
Sch. IX, Line 7	30,329				
kel-Tech Mgmt. Alloc.	628				
Sch. V Line 33, Col. 8	30,957				
				FOR BHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2011	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mulberry Manor COUNTY Union
 FACILITY IDPH LICENSE NUMBER 0025411
 CONTACT PERSON REGARDING THIS REPORT Ashley Alley
 TELEPHONE (618) 833-5070 x11 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-20-03-682</u>	<u>S PT W 1/2 SE S OF RD</u>	\$ <u>28,316.10</u>	\$ <u>28,316.10</u>
2. <u>05-20-03-681</u>	<u>S PT W 1/2 SE S OF RD</u>	\$ <u>820.62</u>	\$ <u>820.62</u>
3. <u>05-20-03-683</u>	<u>S PT W 1/2 SE S OF RD</u>	\$ <u>1,192.36</u>	\$ <u>1,192.36</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>30,329.08</u></u>	\$ <u><u>30,329.08</u></u>

B. Real Estate Tax Cost Allocations

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 X 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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 Mulberry Manor

0025411 Report Period Beginning:

01/01/2012 Ending:

12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,715 B. General Construction Type: Exterior Brick/Block Frame Metal Stud Number of Stories 1

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).

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Healthcare	76,230	1967	\$ 8,687	1
2	Healthcare	45,000	1976	2,700	2
3	TOTALS	121,230		\$ 11,387	3

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

01/01/2012 Ending:

12/31/2012

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	30	1972		\$ 172,058	\$	30	\$	\$	\$ 172,058	4
5	28	1975		151,678		27			151,678	5
6	6	1979		4,663		23			4,663	6
7		1979		40,400		15			40,400	7
8		1987		16,300		30	543	543	13,848	8
Improvement Type**										
9	Gazebo	1986		2,561		5			2,561	9
10	Laundry Room	1990		18,146	576	31.5	454	(122)	10,175	10
11	Landscaping	1990		505		15			505	11
12	Central A/C	1990		9,323		10			9,050	12
13	Improvements - blue House	1991		4,817	153	31.5	120	(33)	2,541	13
14	Blacktop Driveway	1992		3,260		15	81	81	3,260	14
15	New Roof	1992		8,055		15	198	198	8,055	15
16	Remodeled Living Room	1992		1,203		15	33	33	1,203	16
17	Remodeling	1985		1,867		15			1,867	17
18	Remodeling - Rest Room	1988		10,790		15			10,790	18
19	Seamless Gutters	1993		1,536		15	77	77	1,501	19
20	A/C & Heaters	1993		8,823		15	441	441	8,600	20
21	Dining Room Improvements	1995		9,127		15	456	456	7,752	21
22	Bath, Carpet & Fencing	1995		4,428		15			4,428	22
23	Carpet	1997		1,684		7			1,684	23
24	Smoking Room Addition	1997		46,392	1,189	39	1,160	(29)	17,497	24
25	Smoking Room Equipment	1998		952		7			952	25
26	A/C - C Wing	1998		2,446	163	15	163		2,363	26
27	Kitchen Cabnets	1998		779		7			779	27
28	A/C Office	1998		1,059	71	15	71		1,029	28
29	Storage Building	1999		3,857	257	15	257		3,469	29
30	Water Garden	2001		2,922	195	15	195		2,161	30
31	A/C Compressor	2001		1,027	69	15	68	(1)	794	31
32	Fire Supression System	2003		1,716	80	15	114	34	1,131	32
33	Jo ann's Office Remodel	2003		8,543	399	15	570	171	5,557	33
34	A/C Laundry Room	2003		1,068	36	15	71	35	675	34
35	Furnace - Blue House	2004		2,213	65	15	148	83	1,319	35
36	Stopper II Fire Alarm	2004		637		7			637	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 Mulberry Manor

0025411

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Vinyl Fence	2004	\$ 5,350	\$ 158	15	\$ 357	\$ 199	\$ 2,975	37
38	A/C Unit Roof Mount	2004	2,473	73	15	165	92	1,430	38
39	Vinyl Windows	2005	411	27	15	27		214	39
40	Carpet Office	2006	954		7	136	136	918	40
41	Flooring - Blue House	2006	1,397	93	15	93		574	41
42	Lumber - Blue House	2006	1,742	116	15	116		706	42
43	Drainage System	2006	8,909	594	15	594		3,613	43
44	Base Board - Carpet	2006	96		7	14	14	85	44
45	Door Alarm / Bumber Guard	2007	1,315	88	15	88		484	45
46	Windows	2008	783	26	15	52	26	241	46
47	Roof - Laundry Room	2008	1,239	41	15	83	42	384	47
48	New Wall	2009	598	23	15	40	17	130	48
49	Fire Doors	2010	1,491	64	15	99	35	264	49
50	Door Knobs & Keys	2010	835	36	15	56	20	149	50
51	Sprinkler System	2011	9,462	2,607	7	1,352	(1,255)	1,352	51
52	Shower	2011	998	96	15	67	(29)	95	52
53	Gravel	2011	185	18	15	12	(6)	12	53
54	Sprinkler System	2012	60,000	60,000	7	7,857	(52,143)	7,857	54
55	Water System Upgrade	2012	10,460	5,492	15	639	(4,853)	639	55
56	Sprinkler System	2012	1,206	1,206	7	129	(1,077)	129	56
57	Compressor Unit	2012	2,090	2,090	5	124	(1,966)	124	57
58	Door Alarm	2012	1,374	1,374	5	92	(1,282)	92	58
59	Security System	2012	2,115	2,115	5	71	(2,044)	71	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)		\$ 660,318	\$ 79,590		\$ 17,483	\$ (62,107)	\$ 517,520	70

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

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	\$ 64,618	\$ 139	\$ 7,958	\$ 7,819		\$ 48,850	71
72	Current Year Purchases	5,777	5,777	569	(5,208)		569	72
73	Fully Depreciated Assets	91,634					91,634	73
74								74
75	TOTALS	\$ 162,029	\$ 5,916	\$ 8,527	\$ 2,611		\$ 141,053	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	Healthcare	1993 Ford Van	1993	\$ 25,942	\$	\$	\$	5	\$ 25,942	76
77	Healthcare	1997 Ford Van	1997	25,653				5	25,653	77
78	Healthcare	1998 Ford Van	1999	29,272				5	29,272	78
79	See Pg. 24	See Pg. 24		36,881	1,878	2,127	249	5	36,552	79
80	TOTALS			\$ 117,748	\$ 1,878	\$ 2,127	\$ 249		\$ 117,419	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)	\$ 951,482	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,384	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,137	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (59,247)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 775,992	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	Rental Property - Building	\$ 59,013	\$ 2,146	\$ 19,309	86
87	Rental Prop. - Furniture & Fixtures	1,141		1,141	87
88	Rental Property - Improvements	5,961	231	3,720	88
89	Rental Property - Land	5,000			89
90					90
91	TOTALS	\$ 71,115	\$ 2,377	\$ 24,170	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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 Mulberry Manor

0025411

Report Period Beginning:

01/01/2012

Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party

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. _____/2013 \$ _____

13. _____/2014 \$ _____

14. _____/2015 \$ _____

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: \$ 2,774

Description: See Pg. 24

(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					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.

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? <input checked="" type="checkbox"/> YES <input 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 checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></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)	402	553		955
4	Clinical Wages (b)	784	1,078		1,862
5	In-House Trainer Wages (c)	1,473	2,026		3,499
6	Transportation				
7	Contractual Payments	735	490		1,225
8	CNA Competency Tests				
9	TOTALS	\$ 3,394	\$ 4,147	\$	\$ 7,541
10	SUM OF line 9, col. 1 and 2 (e)	\$ 7,541			

- (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.

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	<u>1</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>4</u>
2. From other facilities (f)	
TOTAL TRAINED	5

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							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			\$		\$	\$		\$	14	

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

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 01/01/2012Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

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	\$ 590,398	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	938,612		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,651,629		8
9	Other(specify): <u>See Pg. 24</u>	1,643		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,182,282	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	64,013		14
15	Leasehold Improvements, at Historical Cost	268,524		15
16	Equipment, at Historical Cost	280,919		16
17	Accumulated Depreciation (book methods)	(482,860)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			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)	\$ 130,596	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,312,878	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 34,179	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	31,490		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,652		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,531		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Day Training Payable</u>	57,206		36
37	<u>See Pg. 24</u>	40,630		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 209,688	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 209,688	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,103,189	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,312,877	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,709,427	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,709,427	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	393,762	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	()	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)	\$ 393,762	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)	\$ 3,103,189	24 *

* This must agree with page 17, line 47.

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	\$ 2,521,894	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,521,894	3	
B. Ancillary Revenue				
4	Day Care	868,281	4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 868,281	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements	1,755	11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs		17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services		21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,755	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	1,337	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,337	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,393,267	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	505,111	31	
32	Health Care	1,795,992	32	
33	General Administration	454,807	33	
B. Capital Expense				
34	Ownership	99,581	34	
C. Ancillary Expense				
35	Special Cost Centers		35	
36	Provider Participation Fee	150,014	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,005,505	40	
41	Income before Income Taxes (line 30 minus line 40)**	387,762	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 387,762	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** 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 Mulberry Manor

0025411

Report Period Beginning:

01/01/2012

Ending:

12/31/2012

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	2,047	2,087	\$ 45,917	\$ 22.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,987	2,108	31,719	15.05	3
4	Licensed Practical Nurses	7,993	8,146	119,774	14.70	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,039	2,139	25,176	11.77	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,150	2,278	31,862	13.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,509	8,811	86,489	9.82	15
16	Dishwashers					16
17	Maintenance Workers	2,298	2,298	41,588	18.10	17
18	Housekeepers	3,752	3,921	36,203	9.23	18
19	Laundry					19
20	Administrator	2,083	2,083	104,460	50.15	20
21	Assistant Administrator	522	522	10,868	20.82	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,085	2,197	31,644	14.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	5,802	5,979	107,649	18.00	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	51,269	52,656	506,044	9.61	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	92,536	95,225	\$ 1,179,393 *	\$ 12.39	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	132	\$ 5,940	1-3	35
36	Medical Director	96	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	6	220	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	103	3,525	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	237	9,490	12-3	45
46	Other(specify) <u>Dental Consultant</u>	As Needed	1,200	10a-3	46
47	<u>Psychologist Consultant</u>	40	3,000	10a-3	47
48	<u>See Pg. 24</u>		7,000	10a-3	48
49	TOTAL (lines 35 - 48)	614	\$ 37,575		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Mulberry Manor

0025411

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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	
JoAnn Keller	Administrator	50	\$ 104,460	Workers' Compensation Insurance	\$ 42,209	IDPH License Fee	\$	
Susan Middleton	Asst. Admin.	0	10,868	Unemployment Compensation Insurance	17,983	Advertising: Employee Recruitment	718	
				FICA Taxes	85,850	Health Care Worker Background Check		
				Employee Health Insurance	17,483	(Indicate # of checks performed <u>2</u>)	32	
				Employee Meals	67	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		See Pg. 24	2,184	
				Staff Vaccinations	613	kel-Tech Allocation	265	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 115,328	kel-Tech Management Allocation	12,589	Less: Public Relations Expense	()	
B. Administrative - Other				Less:		Non-allowable advertising	()	
Description			Amount	Staff Meals	(67)	Yellow page advertising	()	
			\$	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 176,727		\$ 3,199	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
Barnett & Levine	CPA		\$ 2,405					
kel-Tech Management Co.	Mgmt./Acct'g Services		102,000				In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 104,405	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	

* Attach copy of IMRF notifications

**See instructions.

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												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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? _____
- (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? _____
- (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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,693 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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 150,014
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? Yes 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? N/A
- (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. \$ 67 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
 - c. What percent of all travel expense relates to transportation of nurses and patients? 100%
 - d. Have vehicle usage logs been maintained? Yes
 - 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? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Mulberry Manor, Inc.
Sch. V, Line 20, Col. 8
Analysis of Dues, Fees & Subscriptions
2012

Subscriptions	\$	554
Memberships		
MES of IL		175
Sams Club Membership		70
IL Nursing Home Admin. Assoc.		200
Contributions		(50)
License Fees		635
Fingerprinting		406
IDPH Fine		3,250
Website Hosting Fee		144
Advertising		212
Less		
Advertising		(212)
Contributions		50
IDPH Fine		<u>(3,250)</u>
	\$	<u>2,184</u>

Mulberry Manor, Inc.
Reconciliation Sch. XI, Col. 6, Line 83 to
Sch. V, Line 30, Col. 8
2012

Sch. XI, Col. 6, Line 83	\$	28,137
kel-Tech Mgmt Allocation		976
Sch. V, Line 30, Col. 8	\$	<u>29,113</u>

Mulberry Manor, Inc.
Sch. V Line 36, Col. 3
2012

Insurance - Officers's Life	246
State Income Tax	(12,300)
Federal Income Tax	(254,783)
Total	<u>\$ (266,837)</u>

Mulberry Manor, Inc.
 Details for Sch. XI, Line 79
 2012

Use	Model, Make and Year	Year Acquired	Cost	Current Book Deprec	S/L Deprec.	Adjust.	Life In Yrs	Acc. Deprec.
Healthcare	2007 Buick Terraza	2007	35001	1775	1751	-24	5	35001
Healthcare	1999 Ford Transmission	2008	1880	103	376	273	5	1551
			36881	1878	2127	249		36552

Mulberry Manor, Inc.
 Sch. XV Line 9
 2012

A/R Employee Advances	\$ 1,418
A/R Residents	\$ 225
Total	<u>\$ 1,643</u>

Mulberry Manor, Inc.
 Sch. XVIII Sec. B Line 48
 2012

	# Hours	Total Cost	Sch. V Ref.
Psychiatric Consultant	80	6000	10a-3
Behavior Therapist	13	1000	10a-3
Total		<u>\$ 7,000</u>	

Mulberry Manor
 Sch. XII Sec. B Line 16.
 2012

Oxygen Tank Rental	1238
Copy Machine Rental	1536

Total Leased Equipment

\$2,774

Mulberry Manor
Sch. XV Line 37
2012

Payroll Deductions Payable	1612
Other Insurance Payable	1028
Accrued Assessments	37515
Client Memorial Fund	475
	<u>\$40,630</u>

Mulberry Manor
Analysis Allocated Hours & Wages
Sch18, Line 29 & 30, Col 1-4
2012

Susan Middleton, QSP, Assistant Administrator
Allocation of wages:

QSP	75%	32,488
Asst. Admin.	25%	<u>10,829</u>
Total	100%	<u>\$43,317</u>