

		FOR BHF USE					

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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: <u>0025411</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Mulberry Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2012</u> to <u>12/31/2012</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>612 East Davie Street, Box 88</u> <u>Anna</u> <u>62906</u>																									
NumberCityZip Code																									
County: <u>Union</u>																									
Telephone Number: <u>(618) 833-6012</u> Fax # <u>(618) 833-4993</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Ashley Alley</u></td></tr><tr><td>(Title) <u>Asst. Comptroller</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Ashley Alley</u>	(Title) <u>Asst. Comptroller</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Ashley Alley</u>																								
	(Title) <u>Asst. Comptroller</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>01/01/1972</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☒ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☒ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
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IRS Exemption Code _____	☒ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		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																							
Name: <u>Ashley Alley</u> Telephone Number: <u>(618) 833-5070 x11</u>																									
Email Address: _____																									

Facility Name & ID Number	Mulberry Manor
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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

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*	☐
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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.**

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	64	ICF/DD 16 or Less	64	23,424		6	
7	64	TOTALS	64	23,424		7	

B. Census-For the entire report period.

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

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

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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
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
	GRAND TOTAL COST											
45	(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.

		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

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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
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
	TOTAL Operating Expense													
29	(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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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
45	GRAND TOTAL COST (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
<u>JoAnn Keller</u>	<u>50</u>	<u>Pilot House</u>	<u>Cairo</u>	<u>kel-Tech Mgmt. Co.</u>	<u>Anna</u>	<u>Mgmt. Services</u>
<u>James K. Keller Family Trust</u>	<u>50</u>	<u>Lincoln Square</u>	<u>Jonesboro</u>	<u>JR's Center</u>	<u>Anna</u>	<u>Workshop</u>
		<u>Glen Brook</u>	<u>Vienna</u>	<u>ILS 1-3 & 5-6</u>	<u>Anna</u>	<u>CILA</u>
		<u>Krypton</u>	<u>Metropolis</u>	<u>ILS 4</u>	<u>Metropolis</u>	<u>CILA</u>
		<u>New Way</u>	<u>Anna</u>	<u>ILS Land Trust</u>	<u>Anna</u>	<u>Land Trust</u>
				<u>CIL</u>	<u>Anna</u>	<u>CILA</u>

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 Item	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)	
1	V	3	<u>Houskeeping</u>	\$	<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>\$ 225</u>	<u>\$ 225</u>	<u>1</u>
2	V	5	<u>Heat & Other Utilities</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>784</u>	<u>784</u>	<u>2</u>
3	V	6	<u>Maintenance</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>467</u>	<u>467</u>	<u>3</u>
4	V	14	<u>Program Transportation</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>3,278</u>	<u>3,278</u>	<u>4</u>
5	V	19	<u>Professional Services</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>296</u>	<u>296</u>	<u>5</u>
6	V	20	<u>Dues, Fees, & Subscriptions</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>265</u>	<u>265</u>	<u>6</u>
7	V	21	<u>Clerical & General</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>3,852</u>	<u>3,852</u>	<u>7</u>
8	V	22	<u>Employee Benefits</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>12,589</u>	<u>12,589</u>	<u>8</u>
9	V	24	<u>Inservice Trn'g & Education</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>30</u>	<u>30</u>	<u>9</u>
10	V	26	<u>Insurance</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>660</u>	<u>660</u>	<u>10</u>
11	V	30	<u>Depreciation</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>976</u>	<u>976</u>	<u>11</u>
12	V	33	<u>Real Estate Taxes</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>628</u>	<u>628</u>	<u>12</u>
13	V	34	<u>Rent- Facility</u>		<u>kel-Tech Management Co.</u>	<u>25.00%</u>	<u>2,144</u>	<u>2,144</u>	<u>13</u>
14	Total			\$			<u>\$ 26,194</u>	<u>\$ * 26,194</u>	<u>14</u>

* 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	15
16	V	10	Nursing		kel-Tech Management Co.		4,413	4,413	16
17	V	17	Administration		kel-Tech Management Co.		21,050	21,050	17
18	V	21	Clerical		kel-Tech Management Co.		28,327	28,327	18
19	V	6	Maintenance		kel-Tech Management Co.		21,809	21,809	19
20	V								20
21	V								21
22	V	19	Professional Services	102,000	kel-Tech Management Co.	25.00%		(102,000)	22
23	V	34	Building Lease	240,000	J & J Partners	100.00%		(240,000)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 342,000			\$ 75,747	\$ * (266,253)	39

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

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 ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	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

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 ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

	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	102,000	4,414	9
10	17	Administration	Mgmt Fee Contribution	342,496	8	70,684	70,684	102,000	21,051	10
11	21	Clerical	Mgmt Fee Contribution	342,496	8	95,119	95,119	102,000	28,328	11
12	6	Maintenance	Mgmt Fee Contribution	342,496	8	73,235	73,235	102,000	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

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		2		3	4	5	6		7	8	9	10	
	Name of Lender	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							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Southern Trust	X		Operating Line of Credit		5/2012					6.2500	3,554	6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$ 3,554	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$ 3,554	15

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:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. 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)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	05-20-03-682	S PT W 1/2 SE S OF RD	\$ 28,316.10	\$ 28,316.10
2.	05-20-03-681	S PT W 1/2 SE S OF RD	\$ 820.62	\$ 820.62
3.	05-20-03-683	S PT W 1/2 SE S OF RD	\$ 1,192.36	\$ 1,192.36
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 30,329.08	\$ 30,329.08

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.**

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

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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

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.

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

**

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

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	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☒

☐

☐

44

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☒

☐

86

B. EXPENSES

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

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		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			

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	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 prescrpts							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.

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

		1	2	
		Operating	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): See Pg. 24	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	2	
		Operating	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	Day Training Payable	57,206		36
37	See Pg. 24	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.

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

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# 0025411Report Period Beginning: 01/01/2012Ending: 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

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 2)	32	
				Employee Meals		67	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*			See Pg. 24	2,184	
				Staff Vaccinations		613			
TOTAL (agree to Schedule V, line 17, col. 1)							kel-Tech Allocation	265	
(List each licensed administrator separately.)			\$ 115,328						
B. Administrative - Other				kel-Tech Management Allocation		12,589			
Description			Amount				Less: Public Relations Expense	()	
			\$	Less:			Non-allowable advertising	()	
				Staff Meals		(67)	Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$ 176,727		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,199	
(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		

*** 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	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
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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?
If YES, give association name and amount.

No
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
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?
If NO, attach a complete explanation.

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
- (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)?
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

YES NO X
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 150,014
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

Yes

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 67
N/A
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No

(18)

Have all costs which do not relate to the provision of long term care been adjusted out 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?
Attach invoices and a summary of services for all architect and appraisal fees.

N/A

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>