

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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 E Davie St Bx 88 Anna 62906 Number City Zip Code County: Union Telephone Number: (618) 833-5070 Fax # (618) 833-4993 HFS ID Number: Date of Initial License for Current Owners: 01/01/1972 Type of Ownership: VOLUNTARY,NON-PROFIT Charitable Corp. Trust IRS Exemption Code X PROPRIETARY Individual Partnership X Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name: Ashlev 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 1/1/2016 to 12/31/2016 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) Ashlev 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
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Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

23126

	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	64	Intermediate/DD	51	23,126	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	51	23,126	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	16,618			16,618	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,618			16,618	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.86%

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

1 (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:

12/31/2016

Fiscal Year:

12/31/2016

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

Facility Name & ID Number **Mulberry Manor** # **0025411** Report Period Beginning: **1/1/2016** Ending: **12/31/2016**

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	85,101	3,865	1,186	90,152		90,152		90,152			1
2	Food Purchase		122,348		122,348		122,348		122,348			2
3	Housekeeping	36,472	20,010		56,482		56,482	341	56,823			3
4	Laundry		5,080		5,080		5,080		5,080			4
5	Heat and Other Utilities			66,462	66,462		66,462	954	67,416			5
6	Maintenance	39,497	22,141	16,356	77,994		77,994	16,738	94,732			6
7	Other (specify):*											7
8	TOTAL General Services	161,070	173,444	84,004	418,518		418,518	18,033	436,551			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	894,552	30,635	13,936	939,123		939,123	4,262	943,385			10
10a	Therapy		5,239	13,861	19,100		19,100		19,100			10a
11	Activities	35,256		862	36,118		36,118		36,118			11
12	Social Services		2,872	2,700	5,572		5,572	(751)	4,821			12
13	CNA Training	16,482		2,205	18,687		18,687		18,687			13
14	Program Transportation		7,789	5,295	13,084		13,084	1,389	14,473			14
15	Other (specify):*			507,908	507,908		507,908	(507,908)				15
16	TOTAL Health Care and Programs	946,290	46,535	553,967	1,546,792		1,546,792	(503,008)	1,043,784			16
	C. General Administration											
17	Administrative	87,725			87,725		87,725	19,874	107,599			17
18	Directors Fees			3,200	3,200		3,200	(3,200)				18
19	Professional Services			102,256	102,256		102,256	(89,677)	12,579			19
20	Dues, Fees, Subscriptions & Promotions			5,710	5,710		5,710	(299)	5,411			20
21	Clerical & General Office Expenses	20,648	10,693	12,723	44,064		44,064	38,989	83,053			21
22	Employee Benefits & Payroll Taxes			164,618	164,618		164,618	8,554	173,172			22
23	Inservice Training & Education			360	360		360		360			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			3,397	3,397		3,397	343	3,740			26
27	Other (specify):* Late Fee/Fin. Charge			45	45		45	(18)	27			27
28	TOTAL General Administration	108,373	10,693	292,309	411,375		411,375	(25,434)	385,941			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,215,733	230,672	930,280	2,376,685		2,376,685	(510,409)	1,866,276			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			14,686	14,686		14,686	19,293	33,979			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			455	455		455	(173)	282			32
33	Real Estate Taxes			34,516	34,516		34,516	655	35,171			33
34	Rent-Facility & Grounds			194,000	194,000		194,000	(191,985)	2,015			34
35	Rent-Equipment & Vehicles			2,631	2,631		2,631	505	3,136			35
36	Other (specify):* See Pg. 24			3,172	3,172		3,172	(3,171)	1			36
37	TOTAL Ownership			249,460	249,460		249,460	(174,876)	74,584			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			115,247	115,247		115,247	(1,417)	113,830			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			115,247	115,247		115,247	(1,417)	113,830			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,215,733	230,672	1,294,987	2,741,392		2,741,392	(686,702)	2,054,690			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$ (507,908)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(836)	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	16,369	30		9
10	Interest and Other Investment Income	(410)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary	(3,200)	18		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	(45)	27		18
19	Entertainment				19
20	Contributions	(95)	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	(2,925)	36		24
25	Fund Raising, Advertising and Promotional	(465)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(2,168)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (501,929)		\$	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 Amount	2 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)	(184,773)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (184,773)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (686,702)		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 Yes	2 No	3 Amount	4 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

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Floral	\$ (203)	12	1
2	Gifts to Clients	(340)	12	2
3	Clothing	(208)	12	3
4	Delinquent Assessment Fine	(1,417)	42	4
5				5
6				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	(2,168)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	341	0	0	0	0	0	0	0	0	0	341	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	954	0	0	0	0	0	0	0	0	0	954	5
6	Maintenance	0	670	16,068	0	0	0	0	0	0	0	0	16,738	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,965	16,068	0	0	0	0	0	0	0	0	18,033	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	4,262	0	0	0	0	0	0	0	0	4,262	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	(751)	0	0	0	0	0	0	0	0	0	0	(751)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	1,389	0	0	0	0	0	0	0	0	0	1,389	14
15	Other (specify):*	(507,908)	0	0	0	0	0	0	0	0	0	0	(507,908)	15
16	TOTAL Health Care and Programs	(508,659)	1,389	4,262	0	0	0	0	0	0	0	0	(503,008)	16
	C. General Administration													
17	Administrative	0	0	19,874	0	0	0	0	0	0	0	0	19,874	17
18	Directors Fees	(3,200)	0	0	0	0	0	0	0	0	0	0	(3,200)	18
19	Professional Services	0	8,597	(98,274)	0	0	0	0	0	0	0	0	(89,677)	19
20	Fees, Subscriptions & Promotions	(560)	261	0	0	0	0	0	0	0	0	0	(299)	20
21	Clerical & General Office Expenses	0	4,743	34,246	0	0	0	0	0	0	0	0	38,989	21
22	Employee Benefits & Payroll Taxes	(836)	9,390	0	0	0	0	0	0	0	0	0	8,554	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	343	0	0	0	0	0	0	0	0	0	343	26
27	Other (specify):*	(45)	27	0	0	0	0	0	0	0	0	0	(18)	27
28	TOTAL General Administration	(4,641)	23,361	(44,154)	0	0	0	0	0	0	0	0	(25,434)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(513,300)	26,715	(23,824)	0	0	0	0	0	0	0	0	(510,409)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	16,369	2,924	0	0	0	0	0	0	0	0	0	19,293	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(410)	237	0	0	0	0	0	0	0	0	0	(173)	32
33	Real Estate Taxes	0	655	0	0	0	0	0	0	0	0	0	655	33
34	Rent-Facility & Grounds	0	0	(191,985)	0	0	0	0	0	0	0	0	(191,985)	34
35	Rent-Equipment & Vehicles	0	0	505	0	0	0	0	0	0	0	0	505	35
36	Other (specify):*	(3,171)	0	0	0	0	0	0	0	0	0	0	(3,171)	36
37	TOTAL Ownership	12,788	3,816	(191,480)	0	0	0	0	0	0	0	0	(174,876)	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	(1,417)	0	0	0	0	0	0	0	0	0	0	(1,417)	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	(1,417)	0	0	0	0	0	0	0	0	0	0	(1,417)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(501,929)	30,531	(215,304)	0	0	0	0	0	0	0	0	(686,702)	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			kel-Tech Mgmt. Co.	Anna	Mgmt. Company
James K. Keller Family Trust	50			JR's Centre	Anna	Workshop
				Indpendent Living Ser	Anna & Metropolis	CILA
				Krypton	Metropolis	CILA
				Lincoln Square	Jonesboro & Dongola	CILA
				Pilot House of Cairo	Cairo	CILA
				Glenbrook of Vienna	Vienna	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 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	Houskeeping	\$	kel-Tech Management Co.	25.00%	\$ 341	\$ 341	1
2	V	5	Heat & Other Utilities		kel-Tech Management Co.	25.00%	954	954	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	670	670	3
4	V	14	Program Transportation		kel-Tech Management Co.	25.00%	1,389	1,389	4
5	V	19	Professional Services		kel-Tech Management Co.	25.00%	8,597	8,597	5
6	V	20	Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	261	261	6
7	V	21	Clerical & General		kel-Tech Management Co.	25.00%	4,743	4,743	7
8	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	9,390	9,390	8
9	V	26	Insurance		kel-Tech Management Co.	25.00%	343	343	9
10	V	27	Late Fee/Finance Charge		kel-Tech Management Co.	25.00%	27	27	10
11	V	30	Depreciation		kel-Tech Management Co.	25.00%	2,924	2,924	11
12	V	32	Interest Notes		kel-Tech Management Co.	25.00%	237	237	12
13	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	655	655	13
14	Total			\$			\$ 30,531	\$ * 30,531	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	34	Rent- Facility	\$	kel-Tech Management Co.	25.00%	\$ 2,015	\$ 2,015	15
16	V	35	Rent - Equipment		kel-Tech Management Co.	25.00%	505	505	16
17	V					25.00%			17
18	V	10	Nursing		kel-Tech Management Co.	25.00%	4,262	4,262	18
19	V	17	Administration		kel-Tech Management Co.	25.00%	19,874	19,874	19
20	V	21	Clerical		kel-Tech Management Co.	25.00%	34,246	34,246	20
21	V	6	Maintenance		kel-Tech Management Co.	25.00%	16,068	16,068	21
22	V								22
23	V								23
24	V	19	Professional Services	98,274	kel-Tech Management Co.	25.00%		(98,274)	24
25	V	34	Building Lease	97,000	JoAnn Keller	50.00%		(97,000)	25
26	V	34	Building Lease	97,000	James K. Keller Family Trust	50.00%		(97,000)	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			\$ 292,274			\$ 76,970	\$ * (215,304)	39

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

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	James A. Keller	50			Glen Brook of Vienna	Vienna	CILA's	1
2	Norine Keller	50			Glen Brook of Vienna	Vienna	CILA's	2
3	Don Pippins	50			CIL	Anna	CILA's	3
4	Denise Pippins	50			CIL	Anna	CILA's	4
5	Don Pippins	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	5
6	Jacob L. Alley	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	6
7	James A. Keller	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	7
8	James K. Keller Family Trust	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	8
9	Jacob L. Alley	33			ILS	Anna & Metropolis	CILA's	9
10	James A. Keller	33			ILS	Anna & Metropolis	CILA's	10
11	James K. Keller Family Trust	33			ILS	Anna & Metropolis	CILA's	11
12	JoAnn Keller	33			ILS	Anna & Metropolis	CILA's	12
13	JoAnn Keller	33			ILS Land Trust	Anna	Land Trust	13
14	Jacob L. Alley	33			ILS Land Trust	Anna	Land Trust	14
15	James A. Keller	33			ILS Land Trust	Anna	CILA's	15
16	James K. Keller Family Trust	33			ILS Land Trust	Anna	CILA's	16
17	Josh Alley	27.5			Krypton	Metropolis	CILA's	17
18	Jacob L. Alley	22.5			Krypton	Metropolis	CILA's	18
19	Diana Alley	22.5			Krypton	Metropolis	CILA's	19
20	Jacob L. Alley, II	27.5			Krypton	Metropolis	CILA's	20
21	Jacob L. Alley	30			Lincoln Square	Jonesboro & Dongola	CILA's	21
22	Diana Alley	30			Lincoln Square	Jonesboro & Dongola	CILA's	22
23	JoAnn Keller	50			Pilot House of Cairo	Cairo	CILA's	23
24	James K. Keller Family Trust	50			Pilot House of Cairo	Cairo	CILA's	24
25	Denise Pippins	16			JR's Centre	Anna	Workshop	25
26	Don Pippins	16			JR's Centre	Anna	Workshop	26
27	JoAnn Keller	16			JR's Centre	Anna	Workshop	27
28								28
29								29
30								30

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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		32	80.00	Administration	\$ 75,000	17-1	1
2	Ashley Alley	QIDP	QIDP	0.00		5	10.00	QIDP	15,201	10-1	2
3	Natasha Davis	LPN	LPN	0.00		40	100.00	LPN	6,190	10-1	3
4											4
5											5
6	kel-Tech Allocation										6
7	Diana Alley							Nursing	4,262		7
8	Jacob Alley							Maintenance	16,068		8
9	James A. Keller							Administration	19,874		9
10	Ashley Alley							Clerical	13,356		10
11											11
12											12
13								TOTAL	\$ 149,951		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:

1/1/2016Ending: 2/31/2016

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 St

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	3	Houskeeping Supplies	Mgmt Fee Contribution	351,160	9	\$ 1,152	\$ 98,274	\$ 322	1
2	3	Home/Office Décor	Mgmt Fee Contribution	351,160	9	68	98,274	19	2
3	5	Utilities Gas	Mgmt Fee Contribution	351,160	9	2,983	98,274	835	3
4	5	Utilities Water	Mgmt Fee Contribution	351,160	9	427	98,274	119	4
5	6	Maint. Building	Mgmt Fee Contribution	351,160	9	491	98,274	137	5
6	6	Maint. Supplies	Mgmt Fee Contribution	351,160	9	106	98,274	30	6
7	6	Grounds Maint.	Mgmt Fee Contribution	351,160	9	1,797	98,274	503	7
8	14	Repairs Vehicle	Mgmt Fee Contribution	351,160	9	157	98,274	44	8
9	14	Transportation	Mgmt Fee Contribution	351,160	9	2,609	98,274	730	9
10	14	Insurance Vehicles	Mgmt Fee Contribution	351,160	9	1,308	98,274	366	10
11	14	Maint. Vehicle	Mgmt Fee Contribution	351,160	9	889	98,274	249	11
12	19	ADP Payroll Services	Mgmt Fee Contribution	351,160	9	26,575	98,274	7,437	12
13	19	Time & Attendance Software	Mgmt Fee Contribution	351,160	9	3,250	98,274	910	13
14	19	Legal & Accounting	Mgmt Fee Contribution	351,160	9	895	98,274	250	14
15	20	Adv. Help Wanted	Mgmt Fee Contribution	351,160	9	365	98,274	102	15
16	20	Contributions	Mgmt Fee Contribution	351,160	9	60	98,274	17	16
17	20	Dues Fees Subscriptions	Mgmt Fee Contribution	351,160	9	508	98,274	142	17
18	21	G & A Misc.	Mgmt Fee Contribution	351,160	9	372	98,274	104	18
19	21	G & A Supplies	Mgmt Fee Contribution	351,160	9	5,111	98,274	1,430	19
20	21	Postage	Mgmt Fee Contribution	351,160	9	1,570	98,274	439	20
21	21	Bank Charges	Mgmt Fee Contribution	351,160	9	1	98,274	0	21
22	21	IT Services	Mgmt Fee Contribution	351,160	9	5,043	98,274	1,411	22
23	21	Software Expense	Mgmt Fee Contribution	351,160	9	715	98,274	200	23
24	21	Telephone	Mgmt Fee Contribution	351,160	9	1,317	98,274	369	24
25	TOTALS					\$ 57,769	\$	16,165	25

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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 St

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	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	
Line Reference									
1	21	Cell Phone Expense	Mgmt Fee Contribution	351,160	9	\$ 1,621	\$ 98,274	\$ 454	1
2	21	Utilities - Internet	Mgmt Fee Contribution	351,160	9	1,200	98,274	336	2
3	22	Ins. Emp. Group	Mgmt Fee Contribution	351,160	9	9,440	98,274	2,642	3
4	22	Ins. W/C	Mgmt Fee Contribution	351,160	9	3,605	98,274	1,009	4
5	22	Payroll Tax Expense	Mgmt Fee Contribution	351,160	9	20,236	98,274	5,663	5
6	22	Staff Meals	Mgmt Fee Contribution	351,160	9	271	98,274	76	6
7	26	Insurance Bldg & Liab	Mgmt Fee Contribution	351,160	9	1,225	98,274	343	7
8	27	Late Fee/Finance Charge	Mgmt Fee Contribution	351,160	9	98	98,274	27	8
9	30	Depreciation	Mgmt Fee Contribution	351,160	9	10,450	98,274	2,924	9
10	32	Interest Notes	Mgmt Fee Contribution	351,160	9	849	98,274	238	10
11	33	Real Estate Taxes	Mgmt Fee Contribution	351,160	9	2,341	98,274	655	11
12	34	Lease Bldg	Mgmt Fee Contribution	351,160	9	7,200	98,274	2,015	12
13	35	Lease Equip	Mgmt Fee Contribution	351,160	9	1,805	98,274	505	13
14	36	Bad Debt	Mgmt Fee Contribution	351,160	9	87	98,274	24	14
15	36	Tax Penalties & Interest	Mgmt Fee Contribution	351,160	9	410	98,274	115	15
16	10	Nursing	Mgmt Fee Contribution	351,160	9	15,228	98,274	4,262	16
17	17	Administration	Mgmt Fee Contribution	351,160	9	71,004	98,274	19,871	17
18	21	Clerical	Mgmt Fee Contribution	351,160	9	122,351	98,274	34,241	18
19	6	Maintenance	Mgmt Fee Contribution	351,160	9	57,405	98,274	16,065	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 326,826	\$ 265,988	\$ 91,465	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	AJ National Bank		X	2010 E-350 Van Loan	\$357.49	4/30/13	\$ 18,489	\$ 5,469	4/30/18	6.0000	\$ 455	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$357.49		\$ 18,489	\$ 5,469			\$ 455	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 18,489	\$ 5,469			\$ 455	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 2015 report.			\$	32,781	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.)			\$	33,716	2
3. Under or (over) accrual (line 2 minus line 1).			\$	935	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	34,200	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.			\$	35,135	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011	30,329	8	
		2012	33,814	9	
		2013	32,394	10	
		2014	35,692	11	
		2015	33,716	12	
Sch. IX, Line 7	35,135			13	FROM R. E. TAX STATEMENT FOR 2015 \$ 13
kel-Tech Mgmt. Alloc	655			14	PLUS APPEAL COST FROM LINE 5 \$ 14
See page 24	-619			15	LESS REFUND FROM LINE 6 \$ 15
Sch V. Line 33, Col 8	35,171			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.

2015 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 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 05-20-03-681	S PT W 1/2 SE S OF RD	\$ 912.26	\$ 912.26
2. 05-20-03-683	S PT W 1/2 SE S OF RD	\$ 1,325.52	\$ 1,325.52
3. 05-20-03-682	S PT W 1/2 SE S OF RD	\$ 31,477.76	\$ 31,477.76
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 33,715.54	\$ 33,715.54

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? X YES 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

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	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		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			4,633	6
7			1979		40,400		15			40,400	7
8			1987		16,300		30	543	543	16,020	8
	Improvement Type**										
9	Gazebo		1986		2,561		5			2,561	9
10	Laundry Room		1990		18,146	576	31.5	454	(122)	11,991	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)	3,021	13
14	Blacktop Driveway		1992		3,260		15			3,260	14
15	New Roof		1992		8,055		15			8,055	15
16	Remodeled Living Room		1992		1,203		15			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			1,536	19
20	A/C & Heaters		1993		8,823		15			8,823	20
21	Dining Room Improvements		1995		9,127		15			9,127	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)	22,137	24
25	Smoking Room Equipment		1998		952		7			952	25
26	A/C - C Wing		1998		2,446		15			2,446	26
27	Kitchen Cabnets		1998		779		7			779	27
28	A/C Office		1998		1,059		15			1,059	28
29	Storage Building		1999		3,857		15			3,857	29
30	Water Garden		2001		2,922	168	15	176	8	2,922	30
31	A/C Compressor		2001		1,027	18	15	29	11	1,027	31
32	Fire Supression System		2003		1,716	80	15	114	34	1,587	32
33	Jo ann's Office Remodel		2003		8,543	399	15	570	171	7,837	33
34	A/C Laundry Room		2003		1,068	36	15	71	35	959	34
35	Furnace - Blue House		2004		2,213	65	15	148	83	1,911	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:

1/1/2016

Ending:

12/31/2016

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	\$ 4,403	37
38	A/C Unit Roof Mount	2004	2,473	73	15	165	92	2,090	38
39	Vinyl Windows	2005	411	27	15	27		322	39
40	Carpet Office	2006	954		7			954	40
41	Flooring - Blue House	2006	1,397	93	15	93		946	41
42	Lumber - Blue House	2006	1,742	116	15	116		1,170	42
43	Drainage System	2006	8,909	594	15	594		5,989	43
44	Base Board - Carpet	2006	96		7			96	44
45	Door Alarm / Bumber Guard	2007	1,315	88	15	88		836	45
46	Windows	2008	783	26	15	52	26	449	46
47	Roof - Laundry Room	2008	1,239	41	15	83	42	716	47
48	New Wall	2009	598	18	15	40	22	290	48
49	Fire Doors	2010	1,491	44	15	99	55	660	49
50	Door Knobs & Keys	2010	835	25	15	56	31	373	50
51	Sprinkler System	2011	9,462	826	7	1,352	526	6,760	51
52	Shower	2011	998	63	15	67	4	363	52
53	Gravel	2011	185	12	15	12		60	53
54	Sprinkler System	2012	60,000		7	8,571	8,571	42,141	54
55	Water System Upgrade	2012	10,460	362	15	697	335	3,427	55
56	Sprinkler System	2012	1,206		7	172	172	817	56
57	Compressor Unit	2012	2,090		5	299	299	1,320	57
58	Door Alarm	2012	1,374		5	275	275	1,192	58
59	Security System	2012	2,115		5	423	423	1,763	59
60	Sprinkler System	2013	7,000		7	1,000	1,000	3,500	60
61	Metal Carport	2015	82	16	5	16		18	61
62	Metal Carport	2015	795	151	5	159	8	179	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 668,195	\$ 5,417		\$ 18,198	\$ 12,781	\$ 591,634	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	\$ 35,476	\$ 1,211	\$ 6,114	\$ 4,903		\$ 25,103	71
72	Current Year Purchases	3,642	2,186	364	(1,822)		364	72
73	Fully Depreciated Assets	144,838					144,838	73
74								74
75	TOTALS	\$ 183,956	\$ 3,397	\$ 6,478	\$ 3,081		\$ 170,305	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
77	Healthcare	1997 Ford Van	1997	25,653				5	25,653
78	Healthcare	1998 Ford Van	1999	29,272				5	29,272
79	Healthcare	See Pg 24		71,484	5,872	6,379	507	5	55,734
80	TOTALS			\$ 152,351	\$ 5,872	\$ 6,379	\$ 507		\$ 136,601

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$ 1,015,889	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 14,686	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 31,055	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ 16,369	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 898,540	

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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: 1/1/2016

Ending: 12/31/2016

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: \$ **2,631** Description: **See Breakdown Pg. 24**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	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. 2017 \$

13. _____ /2018 \$ _____

14. _____/2019 \$ _____

*** 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

ALLOCATION OF COSTS (d)

		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	338	1,982		2,320
4	Clinical Wages (b)	660	3,865		4,525
5	In-House Trainer Wages (c)	1,405	8,232		9,637
6	Transportation				
7	Contractual Payments	490	1,715		2,205
8	CNA Competency Tests				
9	TOTALS	\$ 2,893	\$ 15,794	\$	\$ 18,687
10	SUM OF line 9, col. 1 and 2 (e)	\$ 18,687			

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	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	9

(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
	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	\$ 461,845	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	143,115		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)	1,623,346		8
9	Other(specify): <u>A/R- Other</u>	2,335		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,230,641	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,146		14
15	Leasehold Improvements, at Historical Cost	270,439		15
16	Equipment, at Historical Cost	327,100		16
17	Accumulated Depreciation (book methods)	(540,393)		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)	\$ 59,292	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,289,933	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 42,601	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(20)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,696		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,221		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,200		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Credit Cards Payable</u>	2,874		36
37	<u>Payroll Deductions Payable</u>	3,670		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 134,242	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,469		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)	\$ 5,469	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 139,711	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,150,223	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,289,934	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,435,612	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,435,612	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(285,389)	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)	\$ (285,389)	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)	\$ 2,150,223	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 1,938,721	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,938,721	3
	B. Ancillary Revenue		
4	Day Care	507,908	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 507,908	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	11,340	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)	\$ 11,340	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	410	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 410	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)	\$ 2,458,379	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	418,518	31
32	Health Care	1,546,792	32
33	General Administration	411,375	33
	B. Capital Expense		
34	Ownership	249,460	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	115,247	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,741,392	40
41	Income before Income Taxes (line 30 minus line 40)**	(283,013)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (283,013)	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.

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	2,640	2,784	\$ 66,495	\$ 23.88	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	7,322	7,268	121,573	16.73	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,095	3,214	35,256	10.97	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,156	2,236	33,605	15.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,368	4,536	51,496	11.35	15
16	Dishwashers					16
17	Maintenance Workers	2,250	2,330	39,497	16.95	17
18	Housekeepers	3,453	3,565	36,472	10.23	18
19	Laundry					19
20	Administrator	2,080	2,080	75,000	36.06	20
21	Assistant Administrator	520	540	12,725	23.56	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,435	1,435	20,648	14.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,837	4,033	82,951	20.57	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	55,154	57,562	640,015	11.12	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,310	91,583	\$ 1,215,733 *	\$ 13.27	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	22	\$ 1,186	1-3	35
36	Medical Director	104	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	5	200	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	90	3,125	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	68	2,700	10a-3	45
46	Other(specify) <u>Psychiatric Consult.</u>	80	5,500	10a-3	46
47	<u>Psychologist Consultant</u>	90	3,625	10a-3	47
48	<u>Behavior Therapist</u>	12	1,100	10a-3	48
49	TOTAL (lines 35 - 48)	471	\$ 24,636		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	55	1,996	10-1	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	55	\$ 1,996		53

STATE OF ILLINOIS

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

1/1/2016

Page 21

Ending:

12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name

Function

Ownership %

Amount

JoAnn Keller

Administrator

50

\$ 75,000

Susan Middleton

Asst. Admin.

0

12,725

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 87,725

B. Administrative - Other

Description

Amount

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$

C. Professional Services

Vendor/Payee

Type

Amount

Barnett & Levine

CPA

\$ 2,695

kel-Tech Mgmt

Accounting Services

98,274

FMGR

Legal

1,287

TOTAL (agree to Schedule V, line 19, column 3)

(For legal fee disclosure, see page 39 of instructions)

\$ 102,256

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 37,089

Unemployment Compensation Insurance

12,356

FICA Taxes

91,728

Employee Health Insurance

21,171

Employee Meals

836

Illinois Municipal Retirement Fund (IMRF)*

1,438

Misc. Employee Benefits

9,390

Less: Employee Meals

(836)

TOTAL (agree to Schedule V, line 22, col.8)

\$ 173,172

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,951

Advertising: Employee Recruitment

48

Health Care Worker Background Check (Indicate # of checks performed)

3

Patient Background Checks

3,151

See Pg. 24

261

Less: kel-Tech Allocation

()

Less: Public Relations Expense

()

Non-allowable advertising

()

Yellow page advertising

()

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 5,411

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

Seminar Expense

Entertainment Expense

()

TOTAL (agree to Sch. V, line 24, col. 8)

\$

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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.
\$
Line

1,361
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)?
YES
NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

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.

\$

115,247

(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 benefit on Schedule V.
Has any meal income been offset against related costs?

\$

836

N/A

Indicate the amount.

\$

(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 of Schedule V?

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

N/A

HFS 3745 (N-4-99)

IL478-2471

Mulberry Manor, Inc.
Sch. V, Line 20, Col. 8
Analysis of Dues, Fees & Subscriptions
2016

Subscriptions	\$	400
Sans Club Membership		119
HPSI Membership		175
Annual Lab Services Fee		150
Contributions		95
Fingerprinting		572
Secretary of State		302
LOC Bank Renewal Fee		250
Baughner Financial Fees		111
Advertising		465
Resident Surety Bond		1,072

Less		
Advertising		(465)
Contributions		(95)

\$ 3,151

Mulberry Manor, Inc.
Reconciliation Sch. XI, Col. 6, Line 83 to
Sch. V, Line 30, Col. 8
2016

Sch. XI, Col. 6, Line 83	\$	31,055
kel-Tech Mgmt Allocation		2,924

Sch. V, Line 30, Col. 8 \$ 33,979

Mulberry Manor, Inc.
Sch. V Line 36, Col. 3
2016

Insurance - Officers's Life	246
Bad Debt	2,926

Total \$ 3,172

Mulberry Manor, Inc.
Details for Sch. XI, Line 79
2016

Use	Model, Make and Year	Year Acquired	2007	Cost	35001	Current Book Deprec	1775	S/L Deprec.	0	Adjust.	-1775	Life In Yrs	5	Acc. Deprec.	35001
Healthcare	2007 Buick Terraza														
Healthcare		2008		1880		0		0		0		5		1880	
Healthcare	1999 Ford Transmission														
Healthcare		2013		24723		0		4945		4945		5		17307	
Healthcare	2010 Ford Econoline														
Healthcare		2015		4466		849		893		44		5		1005	
Healthcare	United Access Lift														
Healthcare		2016		5414		3248		541		-2707		5		541	
Healthcare	Wheelchair Lift														
				71484		5872		6379		507				55734	

Mulberry Manor
Analysis Allocated Hours & Wages
Sch18, Line 29 & 30, Col 1-4
2016

Susan Middleton, QSP, Assistant Administrator
Allocation of wages:

QIDP	75%	
Asst. Admin.	25%	
Total	100%	<u>\$0</u>

Mulberry Manor
XII Rental Costs
B. 16 Description Breakdown
2016

Copy Machine Rental	900
Dishwasher Rental	1,731
	<u>\$2,631</u>

Mulberry Manor
IX Real Estate Tax Expense
2016

Accrual Used on 2015 IX - Line 4	32,781
2015 Accrual Error found in 2016	619
Correct Accrual amount 2015	<u>\$33,400</u>