

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ 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: Ashley Alley Telephone Number: (618) 833-5070 x111
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 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)

(Type or Print Name) Ashley Alley

(Title) Asst. Comptroller

Paid Preparer

(Signed) (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

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

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 <u>51</u>					
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	<u>51</u>	Intermediate/DD	<u>51</u>	<u>18,666</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>51</u>	TOTALS	<u>51</u>	<u>18,666</u>	7

B. Census-For the entire report period.					
	1 Level of Care	2 3 4 5 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	<u>16,312</u>			<u>16,312</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>16,312</u>			<u>16,312</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.39%

D. How many bed reserve days during this year were paid by the Department?
37 (Do not include bed reserve 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

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	129,995	4,205	2,731	136,931		136,931		136,931			1
2	Food Purchase		115,845		115,845		115,845		115,845			2
3	Housekeeping	27,500	20,275	228	48,003		48,003	291	48,294			3
4	Laundry	25,455	7,335		32,790		32,790		32,790			4
5	Heat and Other Utilities			69,616	69,616		69,616	741	70,357			5
6	Maintenance	45,415	22,377	4,317	72,109		72,109	807	72,916			6
7	Other (specify):*											7
8	TOTAL General Services	228,365	170,037	76,892	475,294		475,294	1,839	477,133			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,242,860	42,730	10,754	1,296,344		1,296,344	3,476	1,299,820			10
10a	Therapy			6,843	6,843		6,843		6,843			10a
11	Activities	31,940		2,019	33,959		33,959		33,959			11
12	Social Services		1,233	3,150	4,383		4,383	(1,233)	3,150			12
13	CNA Training	15,765		2,560	18,325		18,325		18,325			13
14	Program Transportation		5,548	4,709	10,257		10,257		10,257			14
15	Other (specify):* DT Program Expense			446,437	446,437		446,437	(446,437)				15
16	TOTAL Health Care and Programs	1,290,565	49,511	483,672	1,823,748		1,823,748	(444,194)	1,379,554			16
	C. General Administration											
17	Administrative	54,846		3,000	57,846		57,846	13,709	71,555			17
18	Directors Fees											18
19	Professional Services			75,180	75,180		75,180	(72,875)	2,305			19
20	Dues, Fees, Subscriptions & Promotions			6,295	6,295		6,295	(3)	6,292			20
21	Clerical & General Office Expenses	69,158	8,232	16,179	93,569		93,569	35,513	129,082			21
22	Employee Benefits & Payroll Taxes			183,846	183,846		183,846	4,713	188,559			22
23	Inservice Training & Education			1,815	1,815		1,815		1,815			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,996	18,996		18,996	535	19,531			26
27	Other (specify):* Late Fee			193	193		193	(70)	123			27
28	TOTAL General Administration	124,004	8,232	305,504	437,740		437,740	(18,478)	419,262			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,642,934	227,780	866,068	2,736,782		2,736,782	(460,833)	2,275,949			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			29,055	29,055		29,055	(6,867)	22,188			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(107)	(107)		(107)	(1,757)	(1,864)			32
33	Real Estate Taxes			35,884	35,884		35,884	578	36,462			33
34	Rent-Facility & Grounds			135,001	135,001		135,001	(132,640)	2,361			34
35	Rent-Equipment & Vehicles			2,447	2,447		2,447	96	2,543			35
36	Other (specify):* Officers Life			185	185		185	(185)				36
37	TOTAL Ownership			202,465	202,465		202,465	(140,775)	61,690			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			139,968	139,968		139,968		139,968			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			139,968	139,968		139,968		139,968			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,642,934	227,780	1,208,501	3,079,215		3,079,215	(601,608)	2,477,607			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (446,437)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(13)	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	(11,127)	30		9
10	Interest and Other Investment Income	(1,757)	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	(193)	27		18
19	Entertainment				19
20	Contributions	(25)	20		20
21	Owner or Key-Man Insurance	(185)	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				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 5A	(1,233)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (460,970)		\$	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)	(140,638)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (140,638)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (601,608)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Mulberry Manor

ID# 0025411

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Flowers	\$ (344)	12	1
2	Gifts for Residents	(489)	12	2
3	Church Services @ Facility	(400)	12	3
4				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	(1,233)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
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	291	0	0	0	0	0	0	0	0	0	291	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	741	0	0	0	0	0	0	0	0	0	741	5
6	Maintenance	0	807	0	0	0	0	0	0	0	0	0	807	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,839	0	0	0	0	0	0	0	0	0	1,839	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	3,476	0	0	0	0	0	0	0	0	3,476	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	(1,233)	0	0	0	0	0	0	0	0	0	0	(1,233)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(446,437)	0	0	0	0	0	0	0	0	0	0	(446,437)	15
16	TOTAL Health Care and Programs	(447,670)	0	3,476	0	0	0	0	0	0	0	0	(444,194)	16
	C. General Administration													
17	Administrative	0	0	13,709	0	0	0	0	0	0	0	0	13,709	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	180	(73,055)	0	0	0	0	0	0	0	0	(72,875)	19
20	Fees, Subscriptions & Promotions	(25)	22	0	0	0	0	0	0	0	0	0	(3)	20
21	Clerical & General Office Expenses	0	4,559	30,954	0	0	0	0	0	0	0	0	35,513	21
22	Employee Benefits & Payroll Taxes	(13)	4,726	0	0	0	0	0	0	0	0	0	4,713	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	535	0	0	0	0	0	0	0	0	0	535	26
27	Other (specify):*	(193)	123	0	0	0	0	0	0	0	0	0	(70)	27
28	TOTAL General Administration	(231)	10,145	(28,392)	0	0	0	0	0	0	0	0	(18,478)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(447,901)	11,984	(24,916)	0	0	0	0	0	0	0	0	(460,833)	29

STATE OF ILLINOIS

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	(11,127)	4,260	0	0	0	0	0	0	0	0	0	(6,867)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,757)	0	0	0	0	0	0	0	0	0	0	(1,757)	32
33	Real Estate Taxes	0	0	578	0	0	0	0	0	0	0	0	578	33
34	Rent-Facility & Grounds	0	0	(132,640)	0	0	0	0	0	0	0	0	(132,640)	34
35	Rent-Equipment & Vehicles	0	0	96	0	0	0	0	0	0	0	0	96	35
36	Other (specify):*	(185)	0	0	0	0	0	0	0	0	0	0	(185)	36
37	TOTAL Ownership	(13,069)	4,260	(131,966)	0	0	0	0	0	0	0	0	(140,775)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(460,970)	16,244	(156,882)	0	0	0	0	0	0	0	0	(601,608)	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		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)	
1	V	3	Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 291	\$ 291	1
2	V	5	Heat & Other Utilities		kel-Tech Management Co.	25.00%	741	741	2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	807	807	3
4	V	19	Professional Services		kel-Tech Management Co.	25.00%	180	180	4
5	V	20	Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	22	22	5
6	V	21	Clerical & General		kel-Tech Management Co.	25.00%	4,559	4,559	6
7	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	4,726	4,726	7
8	V	26	Insurance		kel-Tech Management Co.	25.00%	535	535	8
9	V	27	Late Fee/Finance Charge		kel-Tech Management Co.	25.00%	123	123	9
10	V	30	Depreciation		kel-Tech Management Co.	25.00%	4,260	4,260	10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 16,244	\$ * 16,244	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	33 Real Estate Taxes	\$	kel-Tech Management Co.	25.00%	\$ 578	\$	578
16	V	34 Rent-Facility		kel-Tech Management Co.	25.00%	2,361		2,361
17	V	35 Rent-Equipment		kel-Tech Management Co.	25.00%	96		96
18	V							
19	V							
20	V	10 Nursing		kel-Tech Management Co.	25.00%	3,476		3,476
21	V	17 Administration		kel-Tech Management Co.	25.00%	13,709		13,709
22	V	21 Clerical		kel-Tech Management Co.	25.00%	30,954		30,954
23	V							
24	V							
25	V							
26	V	19 Professional Services	73,055	kel-Tech Management Co.	25.00%			(73,055)
27	V	34 Building Lease	67,500	JoAnn Keller	50.00%			(67,500)
28	V	34 Building Lease	67,501	James K. Keller Family Trust	50.00%			(67,501)
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$ 208,056			\$ 51,174	\$ *	(156,882)

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

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	3
4	Jacob L. Alley	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	4
5	James A. Keller	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	5
6	James K. Keller Family Trust	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	6
7	Jacob L. Alley	33.3			ILS	Anna & Metropolis	CILA's	7
8	James A. Keller	33.3			ILS	Anna & Metropolis	CILA's	8
9	James K. Keller Family Trust	16.66			ILS	Anna & Metropolis	CILA's	9
10	JoAnn Keller	16.66			ILS	Anna & Metropolis	CILA's	10
11	JoAnn Keller	33.3			ILS Land Trust	Anna	Land Trust	11
12	Jacob L. Alley	33.3			ILS Land Trust	Anna	Land Trust	12
13	James A. Keller	16.66			ILS Land Trust	Anna	Land Trust	13
14	James K. Keller Family Trust	16.66			ILS Land Trust	Anna	Land Trust	14
15	Josh Alley	27			Krypton	Metropolis	CILA's	15
16	Jacob L. Alley	27			Krypton	Metropolis	CILA's	16
17	Diana Alley	23			Krypton	Metropolis	CILA's	17
18	Jacob L. Alley, II	23			Krypton	Metropolis	CILA's	18
19	Jacob L. Alley	50			Lincoln Square	Jonesboro & Dongola	CILA's	19
20	Diana Alley	50			Lincoln Square	Jonesboro & Dongola	CILA's	20
21	Denise Pippins	33.3			Pilot House of Cairo	Cairo	CILA's	21
22	Diana Alley	33.3			Pilot House of Cairo	Cairo	CILA's	22
23	Jame A. Keller	33.3			Pilot House of Cairo	Cairo	CILA's	23
24	Denise Pippins	16			JR's Centre	Anna	Workshop	24
25	Don Pippins	16			JR's Centre	Anna	Workshop	25
26	JoAnn Keller	16			JR's Centre	Anna	Workshop	26
27								27
28								28
29								29
30								30

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	Diana Alley	DON	DON	0.00	0	1080	50.00	DON	\$ 39,293	10-1	1
2											2
3											3
4											4
5											5
6											6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	3,476		8
9	James A. Keller							Administration	13,709		9
10	Ashley Alley							Clerical	30,954		10
11											11
12											12
13								TOTAL	\$ 87,432		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:1/1/2020Ending: 2/31/2020

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Houskeeping Supplies	Management Fee	276,031	8	\$ 1,281	\$	62,655	\$ 291	1
2	5	Utilities Gas	Management Fee	276,031	8	2,807		62,655	637	2
3	5	Utilities Water	Management Fee	276,031	8	459		62,655	104	3
4	6	Repairs Building	Management Fee	276,031	8	1,535		62,655	348	4
5	6	Maint. Supplies	Management Fee	276,031	8	483		62,655	110	5
6	6	Grounds Maint.	Management Fee	276,031	8	860		62,655	195	6
7	6	Maint. Building	Management Fee	276,031	8	484		62,655	110	7
8	6	Pest Control	Management Fee	276,031	8	194		62,655	44	8
9	19	Legal & Accounting	Management Fee	276,031	8	795		62,655	180	9
10	20	Dues Fees Subscriptions	Management Fee	276,031	8	97		62,655	22	10
11	21	G & A Misc.	Management Fee	276,031	8	231		62,655	52	11
12	21	G & A Supplies	Management Fee	276,031	8	4,215		62,655	957	12
13	21	Postage	Management Fee	276,031	8	1,697		62,655	385	13
14	21	Software Expense	Management Fee	276,031	8	6,846		62,655	1,554	14
15	21	Bank Charges	Management Fee	276,031	8	28		62,655	6	15
16	21	IT Services	Management Fee	276,031	8	2,672		62,655	607	16
17	21	Telephone	Management Fee	276,031	8	1,391		62,655	316	17
18	21	Utilities-Internet	Management Fee	276,031	8	2,100		62,655	477	18
19	22	Ins Emp Group	Management Fee	276,031	8	498		62,655	113	19
20	22	Ins W/C	Management Fee	276,031	8	2,128		62,655	483	20
21	22	Payroll Tax Expense	Management Fee	276,031	8	17,791		62,655	4,038	21
22	22	Staff Meals	Management Fee	276,031	8	401		62,655	91	22
23	26	Insurance Bldg & Liab	Management Fee	276,031	8	2,359		62,655	535	23
24	27	Late Fee/Finance Charge	Management Fee	276,031	8	542		62,655	123	24
25	TOTALS					\$ 51,894	\$		\$ 11,778	25

Facility Name & ID Number Mulberry Manor# 0025411 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Management Fee	276,031	8	\$ 18,767	\$	62,655	\$ 4,260	1
2	32	Interest Other	Management Fee	276,031	8	26		62,655	6	2
3	33	Real Estate Taxes	Management Fee	276,031	8	2,546		62,655	578	3
4	34	Lease Bldg	Management Fee	276,031	8	10,400		62,655	2,361	4
5	35	Lease Equip	Management Fee	276,031	8	423		62,655	96	5
6	36	Tax Penalties and Interest	Management Fee	276,031	8	51		62,655	12	6
7	10	Nursing	Management Fee	276,031	8	15,312	15,312	62,655	3,476	7
8	17	Administration	Management Fee	276,031	8	60,390	60,390	62,655	13,708	8
9	21	Clerical	Management Fee	276,031	8	136,363	136,363	62,655	30,952	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	TOTALS					\$ 244,278	\$ 212,065		\$ 55,449	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	Pilot House	X		Working Capital	NA			217,636				6
7												7
8												8
9	TOTAL Facility Related						\$	217,636			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$	217,636			\$	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

[illegible]

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.

2019 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 x111 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. 05-20-03-681	S PT W 1/2 SE S OF RD	\$ 970.92	\$ 970.92
2. 05-20-03-683	S PT W 1/2 SE S OF RD	\$ 1,410.76	\$ 1,410.76
3. 05-20-03-682	S PT W 1/2 SE S OF RD	\$ 33,501.92	\$ 33,501.92
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 35,883.60	\$ 35,883.60

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
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			16,300	8
	Improvement Type**										
9	Laundry Room			1990	18,146	576	31.5	576		1,753	9
10	Improvements Blue House			1991	4,817	153	31.5	153		4,470	10
11	Smoking Room Addition			1997	46,392	1,190	39	1,190		27,400	11
12	Fire Supression System			2003	1,716		15			1,716	12
13	JoAnn's Office Remodel			2003	8,543		15			8,543	13
14	A/C Laundry Room			2003	1,068		15			1,068	14
15	Furnace - Blue House			2004	2,213		15			2,213	15
16	Vinyl Fence			2004	5,350		15			5,350	16
17	A/C Unit Roof Mount			2004	2,473		15			2,473	17
18	Vinyl Windows			2005	411	19	15	27	8	411	18
19	Flooring - Blue House			2006	1,397	93	15	93		1,314	19
20	Lumber - Blue House			2006	1,742	116	15	116		1,638	20
21	Drainage System			2006	8,909	594	15	594		8,390	21
22	Door Alarm/Bumber Guard			2007	1,315	88	15	88		1,188	22
23	Windows			2008	783	37	15	52	15	783	23
24	Roof-Laundry Room			2008	1,239	58	15	83	25	1,239	24
25	New Wall			2009	598	35	15	35		590	25
26	Fire Doors			2010	1,491	88	15	88		1,425	26
27	Door Knobs & Keys			2010	835	49	15	49		799	27
28	Sprinkler System			2011	9,462		7			9,462	28
29	Shower			2011	998	59	15	59		666	29
30	Gravel			2011	185	11	15	11		120	30
31	Water System Upgrade			2012	10,460	618	15	618		9,379	31
32	Metal Carport			2015	82		5	5	5	82	32
33	Metal Carport			2015	795		5	42	42	795	33
34	Guttering			2017	6,850	527	15	527		2,107	34
35	Roof Improvements			2018	6,693		15	446	446	6,693	35
36											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	Depreciated Improvements	2015	\$ 139,019	\$		\$	\$	\$ 139,019	37
38	Padded Panels & Floors	2019	2,760		15	184	184	2,760	38
39	Front Door	2019	3,469		15	231	231	3,469	39
40	Leasehold Improvements	2020	11,500	11,500	15	383	383	11,500	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									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)		\$ 686,810	\$ 15,811		\$ 5,650	\$ 1,339	\$ 643,914	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	\$ 19,457	\$ 2,301	\$ 6,522	\$ 4,221	5	\$ 15,258	71
72	Current Year Purchases	19,855	8,355	1,218	(7,137)	5	8,355	72
73	Fully Depreciated Assets	180,857					192,357	73
74								74
75	TOTALS	\$ 220,169	\$ 10,656	\$ 7,740	\$ (2,916)		\$ 215,970	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	See Pg. 24			\$ 149,168	\$ 2,588	\$ 4,538	\$ 1,950	5	\$ 137,070	76
77										77
78										78
79										79
80	TOTALS			\$ 149,168	\$ 2,588	\$ 4,538	\$ 1,950		\$ 137,070	80

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)			\$ 1,067,534	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$ 29,055	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$ 17,928	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$ (11,127)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$ 996,954	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		\$	\$	\$
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.

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?

☒ YES

☐ NO
- If NO, see instructions.

		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: \$2,447Description:See Pg. 24 for Breakdown
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

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
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	1,210	1,194		2,404
4	Clinical Wages (b)	2,360	2,328		4,688
5	In-House Trainer Wages (c)	4,366	4,307		8,673
6	Transportation				
7	Contractual Payments	1,360	1,200		2,560
8	CNA Competency Tests				
9	TOTALS	\$ 9,296	\$ 9,029	\$	\$ 18,325
10	SUM OF line 9, col. 1 and 2 (e)	\$ 18,325			

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

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

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

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

(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 prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 533,033	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	222,358		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)	1,658,257		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,413,648	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	301,711		15
16	Equipment, at Historical Cost	369,337		16
17	Accumulated Depreciation (book methods)	(627,625)		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)	\$ 43,423	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,457,071	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 24,234	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,585		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,871		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Liabilities</u>	24,856		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 107,046	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	217,636		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)	\$ 217,636	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 324,682	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,132,389	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,457,071	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,686,679	1
2	Restatements (describe):		2
3	Annual Adjustment to Retained Earnings	(67,049)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,619,630	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	512,759	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)	\$ 512,759	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)	\$ 2,132,389	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 2,616,931	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,616,931	3
	B. Ancillary Revenue		
4	Day Care	446,437	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 446,437	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	3,841	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)	\$ 3,841	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,011	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,011	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)	26	27
28	PPP Funds	283,300	28
28a	CARES Act Funds	241,804	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 525,130	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,594,350	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	475,294	31
32	Health Care	1,823,748	32
33	General Administration	437,740	33
	B. Capital Expense		
34	Ownership	202,465	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	139,968	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,079,215	40
41	Income before Income Taxes (line 30 minus line 40)**	515,135	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 515,135	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? Yes 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	2,080	2,080	\$ 78,646	\$ 37.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,669	5,861	173,576	29.62	3
4	Licensed Practical Nurses	23	23	542	23.57	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,196	31,940	14.54	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,148	2,188	37,801	17.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,577	6,906	92,194	13.35	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,136	45,415	21.26	17
18	Housekeepers	2,429	2,469	27,500	11.14	18
19	Laundry	2,080	2,200	25,455	11.57	19
20	Administrator					20
21	Assistant Administrator	2,080	2,136	54,846	25.68	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,234	4,306	69,158	16.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,080	2,200	41,213	18.73	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	91,435	94,965	964,648	10.16	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,995	129,666	\$ 1,642,934 *	\$ 12.67	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	49	\$ 2,731	1-3	35
36	Medical Director	104	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	2,450	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	44	1,750		43
44	Activity Consultant				44
45	Social Service Consultant	79	3,150	10a-3	45
46	Other(specify) <u>Psychologist Consulta</u>	55	2,175	10a-3	46
47	<u>Admin. Consultant</u>	60	3,000	17-3	47
48					48
49	TOTAL (lines 35 - 48)	415	\$ 22,456		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

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? No If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,284 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 139,968
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 13 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____

c. What percent of all travel expense relates to transportation of nurses and patients? 100%

d. Have vehicle usage logs been maintained? Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____

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

Mulberry Manor, Inc.
Sch. V, Line 20, Col. 8
Analysis of Dues, Fees & Subscriptions
2020

Subscriptions	\$	256
Contributions		25
Secretary of State		532
Food License & Permits		335
Resident Surety Bond		1,020

Less		
Contributions		(25)
	\$	<u>2,143</u>

Mulberry Manor, Inc.
Reconciliation Sch. XI, Col. 6, Line 83 to
Sch. V, Line 30, Col. 8
2020

Sch. XI, Col. 6, Line 83	\$	17,928
kel-Tech Mgmt Allocation		4,260

Sch. V, Line 30, Col. 8	\$	<u>22,188</u>
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Mulberry Manor, Inc.
Details for Sch. XI, Line 79
2020

Use	Model, Make and Year	Year Acquired	Cost	Current Book Deprec	S/L Deprec.	Adjust.	Life In Yrs	Acc. Deprec.
Healthcare		1993	25942					25942
1993 Ford Van								
Healthcare		1999	29272					29272
1998 Ford Van								
Healthcare		2007	35001				5	35001
2007 Buick Terraza								
Healthcare		2008	1880				5	1880
1999 Ford Transmission								
Healthcare		2013	24723				5	24723
2010 Ford Econoline								
Healthcare		2015	4466			0	5	4466
United Access Lift								
Healthcare		2016	5414			0	5	5414
Wheelchair Lift								
Healthcare		2017	20915			0	5	20915
2016 Ford Transit								
Healthcare		2017	1555			0	5	1555
Motor								
			149168	0	0	0		149168

Mulberry Manor
XII Rental Costs
B. 16 Description Breakdown
2020

Wells Fargo Copy Machine Rental	150
CDS Copy Machine Lease	1,004
Dishwasher Rental	<u>1,293</u>
	<u>\$2,447</u>