

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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) 833-4996

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

Corporation

X "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 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 1/1/2025 to 12/31/2025 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)

(Type or Print Name) Ashley Alley

(Title) CFO

Paid Preparer

(Print Name and Title)

(Firm Name & Address)

(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Ending: 12/31/2025

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

B. Census-For the entire report period.									
	1	2	3	4	5	6	7	8	9
	Level of Care	Patient Days by Level of Care and Primary Source of Payment							
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total
				Medicaid Primary	Medicare Primary				
8	SNF								8
9	SNF/PED								9
10	ICF								10
11	ICF/DD	15,899						15,899	11
12	SC								12
13	DD 16 OR LESS								13
14	TOTALS	15,899						15,899	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)	85.41%
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Facility Name & ID Number **Mulberry Manor** # **0025411** Report Period Beginning: **1/1/2025** Ending: **12/31/2025**
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	175,573	6,542	2,750	184,865		184,865		184,865			1
2	Food Purchase		199,990		199,990		199,990		199,990			2
3	Housekeeping	28,214	19,006		47,220		47,220	63	47,283			3
4	Laundry	37,267	3,446	120	40,833		40,833		40,833			4
5	Heat and Other Utilities			101,486	101,486		101,486	728	102,214			5
6	Maintenance	50,859	25,806	14,463	91,128		91,128	596	91,724			6
7	Other (specify):*											7
8	TOTAL General Services	291,913	254,790	118,819	665,522		665,522	1,387	666,909			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	1,457,704	25,688	10,398	1,493,790		1,493,790	306	1,494,096			10
10a	Therapy		924	2,550	3,474		3,474		3,474			10a
11	Activities	68,324			68,324		68,324		68,324			11
12	Social Services		5,217	4,700	9,917		9,917	(496)	9,421			12
13	CNA Training	2,496		4,275	6,771		6,771		6,771			13
14	Program Transportation		11,876	9,018	20,894		20,894		20,894			14
15	Other (specify):* DT PROGRAM			969,870	969,870		969,870	(969,870)				15
16	TOTAL Health Care and Programs	1,528,524	43,705	1,011,811	2,584,040		2,584,040	(970,060)	1,613,980			16
	C. General Administration											
17	Administrative	106,889			106,889		106,889	17,346	124,235			17
18	Directors Fees											18
19	Professional Services			54,200	54,200		54,200	(52,787)	1,413			19
20	Dues, Fees, Subscriptions & Promotions			2,889	2,889		2,889	27	2,916			20
21	Clerical & General Office Expenses	65,843	24,620	9,630	100,093		100,093	22,750	122,843			21
22	Employee Benefits & Payroll Taxes			227,139	227,139		227,139	3,235	230,374			22
23	Inservice Training & Education			2,971	2,971		2,971		2,971			23
24	Travel and Seminar			111	111		111		111			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			179,225	179,225		179,225	2,643	181,868			26
27	Other (specify):* Late Fee			353	353		353	28	381			27
28	TOTAL General Administration	172,732	24,620	476,518	673,870		673,870	(6,758)	667,112			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,993,169	323,115	1,607,148	3,923,432		3,923,432	(975,431)	2,948,001			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			22,518	22,518		22,518	3,176	25,694			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							15	15			32
33	Real Estate Taxes			41,992	41,992		41,992	53	42,045			33
34	Rent-Facility & Grounds			135,000	135,000		135,000	(133,488)	1,512			34
35	Rent-Equipment & Vehicles			4,131	4,131		4,131	88	4,219			35
36	Other (specify):* Officer Life			246	246		246	27	273			36
37	TOTAL Ownership			203,887	203,887		203,887	(130,129)	73,758			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			190,242	190,242		190,242		190,242			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			190,242	190,242		190,242		190,242			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,993,169	323,115	2,001,277	4,317,561		4,317,561	(1,105,560)	3,212,001			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	\$ (969,870)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(947)	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	2,503	30		9
10	Interest and Other Investment Income				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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(246)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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	(496)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (969,056)		\$	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)	(136,504)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (136,504)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,105,560)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Flowers for Individuals Served	(496)	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
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26				26
27				27
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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	(496)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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	100			kel-Tech Mgmt. Co.	Anna	Mgmt. Company
				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%	\$ 63	\$	63 1
2	V	5	Heat & Other Utilities		kel-Tech Management Co.	25.00%	728		728 2
3	V	6	Maintenance		kel-Tech Management Co.	25.00%	596		596 3
4	V	19	Professional Services		kel-Tech Management Co.	25.00%	313		313 4
5	V	20	Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	27		27 5
6	V	21	Clerical & General		kel-Tech Management Co.	25.00%	3,643		3,643 6
7	V	22	Employee Benefits		kel-Tech Management Co.	25.00%	4,182		4,182 7
8	V	26	Insurance		kel-Tech Management Co.	25.00%	2,643		2,643 8
9	V	27	Late Fee/Interest		kel-Tech Management Co.	25.00%	28		28 9
10	V	30	Depreciation		kel-Tech Management Co.	25.00%	673		673 10
11	V	32	Interest		kel-Tech Management Co.	25.00%	15		15 11
12	V	33	Real Estate Taxes		kel-Tech Management Co.	25.00%	53		53 12
13	V	34	Lease Building		kel-Tech Management Co.	25.00%	1,512		1,512 13
14	Total			\$			\$ 14,476	\$ *	14,476 14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	Lease Equipment	\$	kel-Tech Management Co.	25.00%	\$ 88	\$	88
16	V	36	State Income Tax		kel-Tech Management Co.	25.00%	273		273
17	V								
18	V								
19	V								
20	V								
21	V	10	Nursing		kel-Tech Management Co.	25.00%	306		306
22	V	17	Administration		kel-Tech Management Co.	25.00%	17,346		17,346
23	V	21	Clerical		kel-Tech Management Co.	25.00%	19,107		19,107
24	V								
25	V								
26	V								
27	V								
28	V								
29	V	19	Professional Services	53,100	kel-Tech Management Co.	25.00%			(53,100)
30	V	34	Building Lease	67,500	JoAnn Keller	50.00%			(67,500)
31	V	34	Building Lease	67,500	James K. Keller Family Trust	50.00%			(67,500)
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 188,100			\$ 37,120	\$ *	(150,980)

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

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									\$		1
2											2
3											3
4											4
5											5
6	kel-Tech Allocation										6
7	Diana Alley							Nursing	233	10-1	7
8	James A. Keller							Administration	881	17-1	8
9	Ashley Alley							Administration	17,847	17-1	9
10											10
11											11
12											12
13								TOTAL	\$ 18,961		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: 1/1/2025 Ending: 2/31/2025

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 110 Florsheim Drive
City / State / Zip Code Anna, IL 62906
Phone Number (618) 833-5070
Fax Number (618) 833-4993

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Management Fee	253,200	6	\$ 300	\$	51,000	\$ 60	1
2	5	Utilities - Elec/Gas	Management Fee	253,200	6	2,992		51,000	603	2
3	5	Utilities Water	Management Fee	253,200	6	476		51,000	96	3
4	6	Main. Building	Management Fee	253,200	6	1,318		51,000	265	4
5	6	Grounds Maint.	Management Fee	253,200	6	1,130		51,000	228	5
6	6	Pest Control	Management Fee	253,200	6	170		51,000	34	6
7	6	Misc. Furn & Fix	Management Fee	253,200	6	218		51,000	44	7
8	19	Legal & Accounting	Management Fee	253,200	6	1,490		51,000	300	8
9	20	Dues Fees Subscriptions	Management Fee	253,200	6	126		51,000	25	9
10	21	G & A Misc	Management Fee	253,200	6	329		51,000	66	10
11	21	G & A Supplies	Management Fee	253,200	6	2,554		51,000	514	11
12	21	Poastage	Management Fee	253,200	6	1,205		51,000	243	12
13	21	Software Exp	Management Fee	253,200	6	11,361		51,000	2,288	13
14	21	IT Services	Management Fee	253,200	6	278		51,000	56	14
15	21	Telephone	Management Fee	253,200	6	298		51,000	60	15
16	21	Utilities - Internet	Management Fee	253,200	6	1,327		51,000	267	16
17	22	Ins Emp Group	Management Fee	253,200	6	205		51,000	41	17
18	22	Ins W/C	Management Fee	253,200	6	1,134		51,000	228	18
19	22	Edward Jones IRA	Management Fee	253,200	6	2,949		51,000	594	19
20	22	Payroll Tax Exp	Management Fee	253,200	6	14,963		51,000	3,014	20
21	22	Misc. Emp. Benefits	Management Fee	253,200	6	540		51,000	109	21
22	22	Staff Meals	Management Fee	253,200	6	123		51,000	25	22
23	26	Ins. Building & Liability	Management Fee	253,200	6	4,537		51,000	914	23
24	26	Ins. Cyber	Management Fee	253,200	6	1,233		51,000	248	24
25	TOTALS					\$ 51,256	\$		\$ 10,322	25

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

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 110 Florsheim Drive
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	26	Ins Professional Liab	Management Fee	253,200	6	\$ 6,816	\$	51,000	\$ 1,373	1
2	27	Late Fee/Fin. Charge	Management Fee	253,200	6	133		51,000	27	2
3	30	Depreciation	Management Fee	253,200	6	3,204		51,000	645	3
4	32	Interest Other	Management Fee	253,200	6	72		51,000	15	4
5	33	Real Estate Taxes	Management Fee	253,200	6	251		51,000	51	5
6	34	Lease Building	Management Fee	253,200	6	7,200		51,000	1,450	6
7	35	Lease Equip	Management Fee	253,200	6	419		51,000	84	7
8	36	Bad Debt	Management Fee	253,200	6	582		51,000	117	8
9	36	State & Local Tax	Management Fee	253,200	6	350		51,000	70	9
10	36	Tax Penalties	Management Fee	253,200	6	49		51,000	10	10
11	36	State Income Tax	Management Fee	253,200	6	316		51,000	64	11
12	21	Clerical	Management Fee	253,200	6	98,235	98,235	51,000	19,787	12
13	10	Nursing	Management Fee	253,200	6	1,575	1,575	51,000	317	13
14	17	Administration	Management Fee	253,200	6	89,181	89,181	51,000	17,963	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 208,383	\$ 188,991		\$ 41,973	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 Hosue			Working Capital	N/A			116,000				6
7												7
8												8
9	TOTAL Facility Related						\$	116,000			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$	116,000			\$	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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	41,700	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.)				\$	41,692	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(8)	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	42,000	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.				\$		6
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.				\$	41,992	7
Assessed Value from Real Estate Tax Bill:	2024	1,656,460	8			
Real Estate Tax Bill for Calendar Year:	2020	36,127	9			
	2021	35,337	10			
	2022	36,227	11			
	2023	36,906	12			
	2024	37,910	13			
				14	FROM R. E. TAX STATEMENT FOR 2024 \$	14
				15	PLUS APPEAL COST FROM LINE 5 \$	15
				16	LESS REFUND FROM LINE 6 \$	16
				17	AMOUNT TO USE FOR RATE CALCULATION \$	17

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.

2024 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 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

(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	\$ 1,128.22	\$ 1,128.22
2. 05-20-03-683	S PT W 1/2 SE S OF RD	\$ 1,639.46	\$ 1,639.46
3. 05-20-03-682	S PT W 1/2 SE S OF RD	\$ 38,924.78	\$ 38,924.78
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 41,692.46	\$ 41,692.46

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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.

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 (X) (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? (X) (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. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X 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

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	PADDED PANELS & FLOORS	2019	\$ 2,760	\$	15	\$ 184	\$ 184	\$ 2,760	37
38	FRONT DOOR	2019	3,469		15	231	231	3,469	38
39	OLD OFFICE DEMOLITION	2020	11,500		15	767	767	11,500	39
40	NEW ROOF ON SOUTH WING	2022	80,512	6,199	15	5,370	(829)	24,758	40
41	IMPROVEMENTS	2024	4,552	432	15	303	(129)	660	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)		\$ 771,874	\$ 8,295		\$ 9,026	\$ 731	\$ 696,429	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	\$ 32,730	\$ 8,297	\$ 12,420	\$ 4,123		\$ 20,019	71
72	Current Year Purchases	17,115	3,423	1,072	(2,351)		3,423	72
73	Fully Depreciated Assets	246,884					246,884	73
74								74
75	TOTALS	\$ 296,729	\$ 11,720	\$ 13,492	\$ 1,772		\$ 270,326	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 Attached			\$ 114,167	\$	\$	\$	5	\$ 114,167	76
77										77
78										78
79										79
80	TOTALS			\$ 114,167	\$	\$	\$		\$ 114,167	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,194,157	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,015	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,518	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,503	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,080,922	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		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

**** 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)	148	325		473
4	Clinical Wages (b)	274	601		875
5	In-House Trainer Wages (c)	359	789		1,148
6	Transportation				
7	Contractual Payments	175	4,100		4,275
8	CNA Competency Tests				
9	TOTALS	\$ 956	\$ 5,815	\$	\$ 6,771
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,771			

- (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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	
TOTAL TRAINED	11

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 370,104	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	233,551		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,266		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,502,357		8
9	Other(specify): <u>A/R Residents</u>	1,073		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,159,351	\$	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	386,775		15
16	Equipment, at Historical Cost	414,895		16
17	Accumulated Depreciation (book methods)	(661,506)		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)	\$ 140,164	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,299,515	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 24,123	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	780		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,594		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,909		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Credit Card Payable</u>	1,094		36
37	<u>A/P Other</u>	149,449		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 288,949	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	116,000		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)	\$ 116,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 404,949	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,894,565	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,299,514	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,897,595	1
2	Restatements (describe):		2
3	Previous Year Net Income Adjustment	(4,100)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,893,495	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	71,070	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	(70,000)	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)	\$ 1,070	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)	\$ 1,894,565	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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	\$ 3,416,481	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,416,481	3
	B. Ancillary Revenue		
4	Day Care	969,870	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 969,870	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		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)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,208	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,208	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)	\$ 4,387,559	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	665,522	31
32	Health Care	2,584,040	32
33	General Administration	673,870	33
	B. Capital Expense		
34	Ownership	202,815	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	190,242	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,316,489	40
41	Income before Income Taxes (line 30 minus line 40)**	71,070	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 71,070	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 3,409,834.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	6,647.00	48
49	Medicare Part A		49
50	Other-(specify)		50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,416,481	56

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	1,451	1,451	\$ 60,712	\$ 41.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,545	1,691	70,616	41.76	3
4	Licensed Practical Nurses	11,296	12,072	413,359	34.24	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,511	2,668	68,324	25.61	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,263	2,333	53,841	23.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,299	6,455	121,732	18.86	15
16	Dishwashers					16
17	Maintenance Workers	1,766	2,080	50,859	24.45	17
18	Housekeepers	1,462	1,556	28,214	18.13	18
19	Laundry	1,762	1,881	37,267	19.81	19
20	Administrator	622	622	26,019	41.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,950	2,071	65,843	31.79	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)	1,489	1,673	59,002	35.27	28
29	Resident Services Coordinator	1,857	2,080	80,870	38.88	29
30	Habilitation Aides (DD Homes)	41,391	42,505	856,511	20.15	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	77,664	81,138	\$ 1,993,169 *	\$ 24.57	34

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	44	\$ 2,750	1-3	35
36	Medical Director	120	11,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	49	3,638	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	64	2,550	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	94	4,700	10a-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	371	\$ 24,638		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

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Cheryl Sherrill	Admin	0	\$ 26,019	Workers' Compensation Insurance	\$	35,039	IDPH License Fee	\$	
Eric Chilman	Exec. Dir	0	80,870	Unemployment Compensation Insurance		9,203	Advertising: Employee Recruitment		
				FICA Taxes		153,728	Health Care Worker Background Check	1,190	
				Employee Health Insurance		24,674	(Indicate # of checks performed 17)		
				Employee Meals		947	Patient Background Checks	90	
				Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)		
				Misc. Employee Benefits		3,548	Sec of St	649	
							Surety Bond	510	
							Fees & Subscriptions	450	
							Kel-Tech Allocation	27	
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 106,889				PAC and Lobbying payments	()	
B. Administrative - Other							All non-allowable advertising	()	
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)		
			\$				\$ 2,916		
TOTAL (agree to Schedule V, line 17, col. 3)			\$						
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Kel-Tech Management	Accounting Services		\$ 53,100			\$	Out-of-State Travel	\$	
Whitney Accounting	CPA		1,100						
							In-State Travel		
							Hotel Staff Travel	81	
							Seminar Expense		
							ServeSafe	30	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
(For legal fee disclosure, see page 39 of instructions)			\$ 54,200				TOTAL	\$ 111	

*** Attach copy of IMRF notifications**

****See instructions.**

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

	Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 8,487 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 190,242

This amount is to be recorded on line 42 of Schedule V.
- (8)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

Yes If YES, attach an explanation of the allocation.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ 947 Has any meal income been offset against related costs?

No Indicate the amount. \$
- (12)

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?

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

No
- (13)

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

Firm Name: No
- (14)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (15)

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. Reconciliation Sch. XI, Col. 6, Line 83 to Sch. V, Line 30, Col. 8 2025		
Sch. XI, Col. 6, Line 83	\$	2,503
kel-Tech Mgmt Allocation		673
Sch. V, Line 30, Col. 8	\$	<u>3,176</u>

Mulberry Manor, Inc.
Details for Sch. XI, Line 79
2025

Use	Model, Make and Year	Year Acquired	Cost	Current Book Deprec	S/L Deprec.	Adjust.	Life In Yrs	Acc. Deprec.
Healthcare		1993	25942				5	25942
1993 Ford Van								
Healthcare		1999	29272				5	29272
1998 Ford Van								
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	0	5	20915
2016 Ford Transit								
Healthcare		2017	1555				5	1555
Motor								
			114167	0	0	0		114167

Mulberry Manor
XII Rental Costs
B. 16 Description Breakdown
2025

CDS Copy Machine Lease	1,644
Dishwasher Rental	<u>2,487</u>
	<u>\$4,131</u>

Mulberry Manor
Analysis Allocated Hours & Wages
Sch18, Line 1 & 20, Col 1-4
2025

Cheryl Sherrill, DON & Administrator
Allocation of wages:

DON	70%	60,916
Administrator	30%	<u>26,107</u>
Total	100%	<u>\$87,023</u>