

		FOR OFF USE				

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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 Facility ID Number:** 0025411

**Facility Name:** Mulberry Manor

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

**County:** Union

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

**IDPA ID Number:** 371082826001

**Date of Initial License for Current Owners:** 01/01/72

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Richard Stroh **Telephone Number:** 618 833-5070 ext. 11

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/05 to 12/31/05 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.

<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Richard Stroh</u>	
	(Title) <u>Asst. Comptroller</u>	
<b>Paid Preparer</b>	(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: 1/1/05 Ending: 12/31/05

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 29200

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>80</u>	ICF/DD 16 or Less	<u>80</u>	<u>29,200</u>	6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</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	
8	SNF				8
9	SNF/PED				9
10	ICF				10
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS	<u>27,089</u>	<u>242</u>		<u>27,331</u>
14	TOTALS	<u>27,089</u>	<u>242</u>		<u>27,331</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.60%

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

233 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 1/1/72

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

YES  Date \_\_\_\_\_ NO

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

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

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/05 Ending: 12/31/05

**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	121,917	6,768	8,187	136,872		136,872		136,872		1
2	Food Purchase		167,308		167,308		167,308		167,308		2
3	Housekeeping	64,832	18,565	2,446	85,843		85,843	366	86,209		3
4	Laundry		10,335	28	10,363		10,363		10,363		4
5	Heat and Other Utilities			70,370	70,370		70,370	901	71,271		5
6	Maintenance	48,318	19,897	5,330	73,545		73,545	18,762	92,307		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	235,067	222,873	86,361	544,301		544,301	20,029	564,330		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	760,367	29,563	7,421	797,351		797,351	4,435	801,786		10
10a	Therapy		4,806	12,350	17,156		17,156		17,156		10a
11	Activities	37,157	452	260	37,869		37,869		37,869		11
12	Social Services	71,999	11,025	7,735	90,759		90,759	(6,399)	84,360		12
13	CNA Training	13,924		4,690	18,614		18,614		18,614		13
14	Program Transportation		7,190	5,532	12,722		12,722	1,396	14,118		14
15	Other (specify):* <b>Day Training Exp</b>			965,525	965,525		965,525	(965,525)			15
16	<b>TOTAL Health Care and Programs</b>	883,447	53,036	1,010,713	1,947,196		1,947,196	(966,093)	981,103		16
	<b>C. General Administration</b>										
17	Administrative	169,533			169,533		169,533	21,745	191,278		17
18	Directors Fees							648	648		18
19	Professional Services			124,466	124,466		124,466	(118,795)	5,671		19
20	Dues, Fees, Subscriptions & Promotions			10,417	10,417		10,417	(4,477)	5,940		20
21	Clerical & General Office Expenses	13,642	16,524	17,326	47,492		47,492	39,382	86,874		21
22	Employee Benefits & Payroll Taxes			190,874	190,874		190,874	22,305	213,179		22
23	Inservice Training & Education			762	762		762		762		23
24	Travel and Seminar			1,265	1,265		1,265	26	1,291		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			9,313	9,313		9,313	787	10,100		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	183,175	16,524	354,423	554,122		554,122	(38,379)	515,743		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,301,689	292,433	1,451,497	3,045,619		3,045,619	(984,443)	2,061,176		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mulberry Manor #0025411 Report Period Beginning: 1/1/05 Ending: 12/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			29,651	29,651		29,651	(3,171)	26,480			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,510	3,510		3,510	(3,510)				32
33	Real Estate Taxes			29,225	29,225		29,225	(1,504)	27,721			33
34	Rent-Facility & Grounds			330,000	330,000		330,000	(327,607)	2,393			34
35	Rent-Equipment & Vehicles			1,127	1,127		1,127	1,023	2,150			35
36	Other (specify):* See Pg. 24			228,333	228,333		228,333	(228,333)				36
37	<b>TOTAL Ownership</b>			621,846	621,846		621,846	(563,102)	58,744			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			171,268	171,268		171,268		171,268			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			171,268	171,268		171,268		171,268			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,301,689	292,433	2,244,611	3,838,733		3,838,733	(1,547,545)	2,291,188			45

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

Facility Name & ID Number Mulberry Manor

# 0025411

Report Period Beginning: 1/1/05

Ending: 12/31/05

**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	OHF USE ONLY	
1	Day Care	\$ (965,525)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(120)	22		4
5	Telephone, TV & Radio in Resident Rooms	(530)	12		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,050)	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	(3,510)	32		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	(671)	36		18
19	Entertainment				19
20	Contributions	(3,785)	20		20
21	Owner or Key-Man Insurance	(308)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,371)	36		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(221,983)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(11,678)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (1,218,531)</b>		<b>\$</b>	<b>30</b>

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)	(329,014)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (329,014)</b>		<b>36</b>
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (1,547,545)</b>		<b>37</b>

\*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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

OHF USE ONLY						
48		49		50		51
						52

Mulberry Manor

ID# 0025411  
 Report Period Beginning: 1/1/05  
 Ending: 12/31/05

Sch. V Line  
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Cigarettes	\$ (1,321)	12	1
2	Christmas/Personal	(2,955)	12	2
3	Floral	(397)	12	3
4				4
5	Birthday money	(236)	12	5
6				6
7	Entertainment	(620)	12	7
8				8
9	Vehicle Damage Caused by Resident	(340)	12	9
10	Advertising	(697)	20	10
11	R/E Taxes On Rental Property	(2,133)	33	11
12	Non-Allowable Memberships	(348)	20	12
13	Non-Care Related Depreciation	(2,631)	30	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	<b>Total</b>	(11,678)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

1/1/05

Ending:

12/31/05

**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)	
	<b>A. General Services</b>													
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	366	0	0	0	0	0	0	0	0	0	366	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	901	0	0	0	0	0	0	0	0	0	901	5
6	Maintenance	0	931	17,831	0	0	0	0	0	0	0	0	18,762	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	0	2,198	17,831	0	0	0	0	0	0	0	0	20,029	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,435	0	0	0	0	0	0	0	0	4,435	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	(6,399)	0	0	0	0	0	0	0	0	0	0	(6,399)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	1,396	0	0	0	0	0	0	0	0	0	1,396	14
15	Other (specify):*	(965,525)	0	0	0	0	0	0	0	0	0	0	(965,525)	15
16	<b>TOTAL Health Care and Programs</b>	(971,924)	1,396	4,435	0	0	0	0	0	0	0	0	(966,093)	16
	<b>C. General Administration</b>													
17	Administrative	0	0	21,745	0	0	0	0	0	0	0	0	21,745	17
18	Directors Fees	0	648	0	0	0	0	0	0	0	0	0	648	18
19	Professional Services	0	1,205	(120,000)	0	0	0	0	0	0	0	0	(118,795)	19
20	Fees, Subscriptions & Promotions	(4,830)	353	0	0	0	0	0	0	0	0	0	(4,477)	20
21	Clerical & General Office Expenses	0	6,167	33,215	0	0	0	0	0	0	0	0	39,382	21
22	Employee Benefits & Payroll Taxes	(120)	22,425	0	0	0	0	0	0	0	0	0	22,305	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	26	0	0	0	0	0	0	0	0	0	26	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	787	0	0	0	0	0	0	0	0	0	787	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	(4,950)	31,611	(65,040)	0	0	0	0	0	0	0	0	(38,379)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(976,874)	35,205	(42,774)	0	0	0	0	0	0	0	0	(984,443)	29

STATE OF ILLINOIS

Facility Name & ID Number Mulberry Manor

# 0025411 Report Period Beginning:

1/1/05 Ending:

Summary B

12/31/05

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	(7,681)	0	4,510	0	0	0	0	0	0	0	0	(3,171)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,510)	0	0	0	0	0	0	0	0	0	0	(3,510)	32
33	Real Estate Taxes	(2,133)	629	0	0	0	0	0	0	0	0	0	(1,504)	33
34	Rent-Facility & Grounds	0	2,393	(330,000)	0	0	0	0	0	0	0	0	(327,607)	34
35	Rent-Equipment & Vehicles	0	0	1,023	0	0	0	0	0	0	0	0	1,023	35
36	Other (specify):*	(228,333)	0	0	0	0	0	0	0	0	0	0	(228,333)	36
37	<b>TOTAL Ownership</b>	<b>(241,657)</b>	<b>3,022</b>	<b>(324,467)</b>	<b>0</b>	<b>(563,102)</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(1,218,531)</b>	<b>38,227</b>	<b>(367,241)</b>	<b>0</b>	<b>(1,547,545)</b>	<b>45</b>							

Facility Name & ID Number Mulberry Manor

# 0025411

Report Period Beginning:

1/1/05

Ending:

12/31/05

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JoAnn Keller	50	Pilot House	Cairo	kel-Tech mgnt Co.	Anna	Accting Services
James K. Keller	50	Holly Hill	Anna	JR's Centre	Anna	Workshop
		Lincoln Square	Jonesboro	ILS 1-3	Anna	CILA
		Glen Brook	Vienna	ILS 4	Mertopolis	CILA
		Krypton	Mertopolis			
		New Way	Anna			

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	3 Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 366	\$	366 1
2	V	5 Utilities		kel-Tech Management Co.	25.00%	901		901 2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	931		931 3
4	V	14 Transportation		kel-Tech Management Co.	25.00%	1,396		1,396 4
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	648		648 5
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	1,205		1,205 6
7	V	20 Dues, Fees & Subscriptions		kel-Tech Management Co.	25.00%	353		353 7
8	V	21 Office Expenses		kel-Tech Management Co.	25.00%	6,167		6,167 8
9	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	22,425		22,425 9
10	V	24 Seminar		kel-Tech Management Co.	25.00%	26		26 10
11	V	26 P & C Insurance		kel-Tech Management Co.	25.00%	787		787 11
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	629		629 12
13	V	34 Building Lease		kel-Tech Management Co.	25.00%	2,393		2,393 13
14	Total		\$			\$ 38,227	\$ *	38,227 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 <u>Equipment Lease</u>	\$	<u>kel-Tech Management Co.</u>	25.00%	\$ 1,023	\$ 1,023	15
16	V	10 <u>Nursing</u>		<u>kel-Tech Management Co.</u>	25.00%	4,435	4,435	16
17	V	17 <u>Administration</u>		<u>kel-Tech Management Co.</u>	25.00%	21,745	21,745	17
18	V	21 <u>Clerical</u>		<u>kel-Tech Management Co.</u>	25.00%	33,215	33,215	18
19	V	6 <u>Maintenance</u>		<u>kel-Tech Management Co.</u>	25.00%	17,831	17,831	19
20	V	19 <u>Professional Services</u>	120,000	<u>kel-Tech Management Co.</u>	25.00%		(120,000)	20
21	V	34 <u>Building Lease</u>	330,000	<u>J &amp; J Partners</u>	100.00%		(330,000)	21
22	V	30 <u>Depreciation</u>		<u>kel-Tech Management Co.</u>	25.00%	4,510	4,510	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 450,000			\$ 82,759	\$ * (367,241)	39

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

Facility Name &amp; ID Number

Mulberry Manor

#

0025411

Report Period Beginning:

1/1/05

Ending:

12/31/05

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JoAnn Keller	Owner/Administrator	Administrator	50.00	24,065	32	80.00	Admin. Wages	\$ 102,000	17-1	1
2	Diana Alley	Nursing	QMRP		36,959	5	12.50	QMRP Wages	15,300	10-1	2
3	James K. Keller	Owner	Maintenance	50.00		10	25.00	Maint. Wages	14,400	6-1	3
4	Jake Alley		Program			5	5.00	Program Wage	2,600	10-1	4
5	Ashley Alley		Clerical			10	25.00	Clerical Wage	11,027	10-1	5
6											6
7	kel-Tech Management Allocation										7
8	James A. Keller							Admin. Wage	21,746		8
9	Jacob Alley							Maint. Wage	17,831		9
10	Diana Alley							Nursing Wage	4,435		10
11											11
12											12
13								TOTAL	\$ 189,339		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:

1/1/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Mgmt Fee Contributin	360,999	12	\$ 1100.04	\$ 120,000	\$ 366	1
2	5	UTILITIES ELECT/GAS	Mgmt Fee Contributin	360,999	12	2,401	120,000	798	2
3	5	UTILITIES WATER-B	Mgmt Fee Contributin	360,999	12	309	120,000	103	3
4	6	GROUNDS MAINT	Mgmt Fee Contributin	360,999	12	416	120,000	138	4
5	6	MAINTENANCE SUPPLIES	Mgmt Fee Contributin	360,999	12	245	120,000	81	5
6	6	MAINTENANCE VEHICLE	Mgmt Fee Contributin	360,999	12	119	120,000	39	6
7	6	PREVENTATIVE MAINT	Mgmt Fee Contributin	360,999	12	99	120,000	33	7
8	6	REPAIRS BLDG	Mgmt Fee Contributin	360,999	12	90	120,000	30	8
9	6	REPAIRS FURN/EQUIP	Mgmt Fee Contributin	360,999	12	1,830	120,000	608	9
10	14	REPAIRS VEHICLES	Mgmt Fee Contributin	360,999	12	246	120,000	82	10
11	14	TRANSPORTATION	Mgmt Fee Contributin	360,999	12	3,953	120,000	1,314	11
12	18	DIRECTOR'S FEES	Mgmt Fee Contributin	360,999	12	1,950	120,000	648	12
13	19	LEGAL & ACCOUNTING	Mgmt Fee Contributin	360,999	12	3,625	120,000	1,205	13
14	20	DUES FEES SUBSCRIPTIONS	Mgmt Fee Contributin	360,999	12	1,061	120,000	353	14
15	21	EDUCATIONAL SUPPLIES	Mgmt Fee Contributin	360,999	12	45	120,000	15	15
16	21	BANK CHARGES	Mgmt Fee Contributin	360,999	12	64	120,000	21	16
17	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contributin	360,999	12	243	120,000	81	17
18	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contributin	360,999	12	475	120,000	158	18
19	21	G & A MISC	Mgmt Fee Contributin	360,999	12	484	120,000	161	19
20	21	SUPPLIES STOCK	Mgmt Fee Contributin	360,999	12	793	120,000	264	20
21	21	G & A SUPPLIES	Mgmt Fee Contributin	360,999	12	9,132	120,000	3,036	21
22	21	POSTAGE	Mgmt Fee Contributin	360,999	12	2,525	120,000	839	22
23	21	SOFTWARE EXPENSE	Mgmt Fee Contributin	360,999	12	825	120,000	274	23
24	21	TELEPHONE	Mgmt Fee Contributin	360,999	12	2,400	120,000	798	24
25	TOTALS					\$ 34,429	\$	\$ 11,445	25

Facility Name & ID Number Mulberry Manor

# 0025411

Report Period Beginning:

1/1/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	CELL PHONE EXPENSE	Mgmt Fee Contributin	360,999	12	\$ 1159.34	\$ 120,000	\$ 385	1	
2	21	UTILITIES-INTERNET	Mgmt Fee Contributin	360,999	12	408	120,000	136	2	
3	22	INS EMP GROUP	Mgmt Fee Contributin	360,999	12	43,812	120,000	14,564	3	
4	22	INSURANCE W/C	Mgmt Fee Contributin	360,999	12	3,770	120,000	1,253	4	
5	22	PAYROLL TAX EXPENSE	Mgmt Fee Contributin	360,999	12	19,880	120,000	6,608	5	
6	24	ADM. STAFF TRAINING	Mgmt Fee Contributin	360,999	12	79	120,000	26	6	
7	26	INSURANCE BLDG & LIAB	Mgmt Fee Contributin	360,999	12	1,123	120,000	373	7	
8	26	INSURANCE VEHICLES	Mgmt Fee Contributin	360,999	12	1,245	120,000	414	8	
9	33	REAL ESTATE TAXES	Mgmt Fee Contributin	360,999	12	1,893	120,000	629	9	
10	34	LEASE BLDG	Mgmt Fee Contributin	360,999	12	7,200	120,000	2,393	10	
11	35	LEASE EQUIP	Mgmt Fee Contributin	360,999	12	3,076	120,000	1,023	11	
12	10	NURSING WAGES	Mgmt Fee Contributin	360,999	12	13,341	13,341	120,000	4,435	12
13	17	ADMINISTRATION WAGES	Mgmt Fee Contributin	360,999	12	65,419	65,419	120,000	21,746	13
14	21	CELRICAL WAGES	Mgmt Fee Contributin	360,999	12	99,921	99,921	120,000	33,215	14
15	6	MAINTENANCE WAGES	Mgmt Fee Contributin	360,999	12	53,640	53,640	120,000	17,831	15
16	30	DEPRECIATION	Mgmt Fee Contributin	360,999	12	13,569	120,000	4,510	16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 329,536	\$ 232,321	\$ 109,541	25	

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/05 Ending: 12/31/05

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
<b>Working Capital</b>																				
6										6										
7										7										
8										8										
9	<b>TOTAL Facility Related</b>									9										
<b>B. Non-Facility Related*</b>																				
10	Capaha Bank		X	Rental House Purchase	\$707.84	3/3/04	63,500	54,985	3/3/09	6.0000	3,510	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>				\$707.84		\$ 63,500	\$ 54,985			\$ 3,510	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 63,500	\$ 54,985			\$ 3,510	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ none 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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Mulberry Manor COUNTY Union

FACILITY IDPH LICENSE NUMBER 0025411

CONTACT PERSON REGARDING THIS REPORT Richard Stroh

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 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>05-20-03-681</u>	<u>S PT W 1/2 SE S of RD</u>	\$ <u>1,506.06</u>	\$ <u>1,506.06</u>
2. <u>05-20-03-682</u>	<u>S PT W 1/2 SE S of RD</u>	\$ <u>23,770.46</u>	\$ <u>23,770.46</u>
3. <u>05-20-03-683</u>	<u>S PT W 1/2 SE S of RD</u>	\$ <u>1,748.60</u>	\$ <u>1,748.60</u>
4. <u>05-20-03-679</u>	<u>S20 T12 R1W W PT S PT W 1/2 SE S</u>	\$ <u>2,132.54</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>29,157.66</u>	\$ <u>27,025.12</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Mulberry Manor

# 0025411

Report Period Beginning:

1/1/05

Ending:

12/31/05

**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).

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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

Facility Name &amp; ID Number Mulberry Manor

# 0025411

Report Period Beginning:

1/1/05

Ending:

12/31/05

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	46		1972		\$ 172,058	\$	30	\$	\$	\$ 171,750	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	542	542	10,017	8
	<b>Improvement Type**</b>										
9	Gazebo		1986		2,561		5			2,561	9
10	Laundryroom		1990		18,146	576	31.5	454	(122)	8,893	10
11	Landscaping		1990		505	25	15	25		505	11
12	Central Air		1990		9,323		10	466	466	9,323	12
13	Blue House Improvements		1991		4,817	153	31.5	120	(33)	2,175	13
14	blacktop Driveway		1992		3,260	192	15	163	(29)	2,967	14
15	New Roof		1992		8,055	475	15	403	(72)	7,337	15
16	Remodeled Livingroom		1992		1,203	71	15	60	(11)	1,096	16
17	Seamless Gutters		1993		1,536	91	15	77	(14)	1,311	17
18	A/C & Heaters		1993		8,823	521	15	441	(80)	7,520	18
19	Diningroom Improvements		1995		9,127	609	15	456	(153)	6,166	19
20	Bath Carpet & Fencing		1995		4,428	295	15	296	1	2,802	20
21	Carpet		1997		1,684		7	168	168	1,684	21
22	Smoking Room Addition		1997		46,392	1,189	39	1,160	(29)	9,562	22
23	Smoking Room Equipment		1998		952		7	95	95	952	23
24	A/C C-Wing		1998		2,446	163	15	163		1,222	24
25	Kitchen Cabnets		1998		779		7	78	78	779	25
26	Office A/C		1998		1,059	71	15	71		532	26
27	Storage Building		1999		3,857	257	15	257		1,670	27
28	Water Garden		2001		2,922	195	15	195		804	28
29	A/C Compressor		2001		1,027	69	15	68	(1)	319	29
30	Fire Supression System		2003		1,716	80	15	114	34	715	30
31	JoAnn's Office Remodel		2003		8,543	399	15	570	171	3,560	31
32	A/C Unit Laundry Room		2003		1,068	36	15	71	35	624	32
33	Furnace Blue House		2004		2,213	105	15	148	43	1,267	33
34	Stopper II Fire Alarm		2004		637		7	91	91	637	34
35	Vinyl Fence		2004		5,350	254	15	357	103	3,063	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

Facility Name & ID Number Mulberry Manor

# 0025411

Report Period Beginning:

1/1/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	A/C Roof Mount Unit	2004	\$ 2,473	\$ 117	15	\$ 165	\$ 48	\$ 1,416	37
38	Vinyl Windows	2005	411	14	15	25	11	14	38
39	Remodeling	1985	1,867		15	49	49	1,867	39
40	Remodeling - Rest Rooms	1988	10,790		15	540	540	10,790	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)		\$ 553,069	\$ 5,957		\$ 7,888	\$ 1,931	\$ 472,641	70

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

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 7,827	\$ 514	\$ 1,185	\$ 671	5-7	\$ 6,289	71
72	Current Year Purchases	20,549	20,549	2,025	(18,524)	5-15	20,549	72
73	Fully Depreciated Assets	118,484		10,872	10,872	5-7	118,484	73
74								74
75	TOTALS	\$ 146,860	\$ 21,063	\$ 14,082	\$ (6,981)		\$ 145,322	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Healthcare	Ford Van 1993	1993	\$ 25,942	\$	\$	\$	5	\$ 25,942	76
77	Healthcare	Ford Van 1997	1997	25,653				5	25,653	77
78	Healthcare	Ford Van 1999	1999	29,272				5	29,272	78
79										79
80	TOTALS			\$ 80,867	\$	\$	\$		\$ 80,867	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)		\$ 792,183	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 27,020	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 21,970	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (5,050)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 698,830	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental	\$ 67,775	\$ 2,631	\$ 6,503	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 67,775	\$ 2,631	\$ 6,503	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Mulberry Manor

# 0025411

Report Period Beginning: 1/1/05

Ending: 12/31/05

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 1,127 Description: Medical Equip Rental \$446; Telephone Equipment Rental \$681

(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	<b>TOTAL</b>		\$	\$	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.

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)	1,769	2,951		4,720
4	Clinical Wages (b)	3,449	5,755		9,204
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments	3,115	1,575		4,690
8	CNA Competency Tests				
9	TOTALS	\$ 8,333	\$ 10,281	\$	\$ 18,614
10	SUM OF line 9, col. 1 and 2 (e)	\$ 18,614			

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	7
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	13
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>20</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

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

Facility Name & ID Number Mulberry Manor# 0025411 Report Period Beginning:

1/1/05

Ending:

12/31/05

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

	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	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$	\$		\$	14

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

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 1/1/05

Ending:

12/31/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,306,063	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	407,784		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	106		7
8	Accounts Receivable (owners or related parties)	1,302,186		8
9	Other(specify): <u>Interest &amp; DSP Training Receiva</u>	14,980		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,031,119	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	64,013		14
15	Leasehold Improvements, at Historical Cost	157,935		15
16	Equipment, at Historical Cost	228,867		16
17	Accumulated Depreciation (book methods)	(314,167)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 136,648	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,167,767	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 91,193	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	120		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	50,809		30
31	Accrued Taxes Payable (excluding real estate taxes)	148,497		31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 318,419	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	54,985		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 54,985	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 373,404	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,794,363	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,167,767	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,777,513	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,777,513	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	16,850	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)	\$ 16,850	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 2,794,363	24 *

\* This must agree with page 17, line 47.

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 1/1/05Ending: 12/31/05**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,847,203	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,847,203	3
<b>B. Ancillary Revenue</b>			
4	Day Care	965,525	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 965,525	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	14,089	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	4,800	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 18,889	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	23,966	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 23,966	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,855,583	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	544,301	31
32	Health Care	1,947,196	32
33	General Administration	554,122	33
<b>B. Capital Expense</b>			
34	Ownership	621,846	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	171,268	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,838,733	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	16,850	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 16,850	43

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

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

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Mulberry Manor

# 0025411

Report Period Beginning:

1/1/05

Ending:

12/31/05

**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	2,039	2,079	\$ 43,623	\$ 20.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses	11,325	11,671	149,234	12.79	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,876	4,020	37,157	9.24	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,176	2,304	26,444	11.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,826	10,990	95,473	8.69	15
16	Dishwashers					16
17	Maintenance Workers	2,039	2,159	33,918	15.71	17
18	Housekeepers	7,506	7,926	64,832	8.18	18
19	Laundry					19
20	Administrator	1,664	1,664	102,000	61.30	20
21	Assistant Administrator					21
22	Other Administrative	2,416	2,496	59,933	24.01	22
23	Office Manager					23
24	Clerical	5,180	5,324	50,942	9.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,135	6,239	71,999	11.54	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	68,108	70,082	566,134	8.08	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,290	126,954	\$ 1,301,689 *	\$ 10.25	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	190	\$ 8,187	1-3	35
36	Medical Director	72	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	30	1,500	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	85	4,250	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	221	7,735	12-3	45
46	Other(specify) <u>Dental Consultant</u>	12	1,200	10-3	46
47	<u>Psychologist</u>	43	3,200	10a-3	47
48	<u>Psychiatric Consultant</u>	49	4,900	10a-3	48
49	TOTAL (lines 35 - 48)	702	\$ 38,172		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? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,719 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. \$ 171,268  
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? Yes 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. \$ 120 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Not required of this facility.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

Mulberry Manor, Inc.  
Sch. XIX, Section F.  
Analysis of Dues, Fees, Subscriptions & Promotions  
2005

Advertising	\$ 697.00
Contributions	3,785.00
Subscriptions	692.00
Non-Allowable Memberships	348.00
Purchasing Associations	916.00
IL Corp Annual Report	100.00
Resident Acct. Bond Renewal	900.00
Professional Regulation	200.00
PO Box Rent	138.00
	<u>\$ 7,776.00</u>

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Mulberry Manor, Inc.  
Sch. XVII, Line 43  
Reconciliation of Tax to Book Income  
2005

Adjusted Book Income	\$ 16,850.00
Adjustment for Accrual Changes 2	332,809.00
Adjustment For Non-Deductable Expenses:	
Officer's Life Insurance	308.00
Tax Penalties	<u>671.00</u>
Add (Deduct) Provision For Federal Income Taxes Payable (R	<u>182,796.00</u>
Taxable Income (Loss) Per Federal Income Tax Return	<u>\$ 533,434.00</u>

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Mulberry Manor, Inc.  
Sch. XX, Question 14; Schedule of Costs  
2005

Rental Property Costs Paid By Mulberry Manor

Interest Expense	\$ 3,510.00
R/E Tax Expenses	2,133.00
Depreciation Expense	<u>2,631.00</u>
	<u>\$ 8,274.00</u>

All Non-Allowable Rental Property Expenses  
Removed on Sch. VI

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Mulberry Manor, Inc.  
Sch. V, Line 36, Col. 4  
2005

Bad Debt	\$ 5,371.00
Officer's Life Insurance	308.00
Federal Income Tax	182,796.00
Tax Penalties	671.00
State Income Taxes	<u>39,187.00</u>
	<u>\$ 228,333.00</u>

Related Parties Schedule VII  
 Owners Compensation  
 Jan 1, 2005 - Dec 31, 2005

	Totals / Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Liberty House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 134,362	11,964	11,077	22,000			6,000			43,279		40,042
Denise Pippins	\$ 87,416	25,964	21,058	40,394								
Diana Alley	\$ 103,421	11,964	28,221	9,600	15,300			24,030	13,341			965
Jo Ann Keller	\$ 140,988			14,923	102,000	24,065						
James K. Keller	\$ 29,323			14,923	14,400							
Jacob Alley	\$ 50,613								50,613			
Jake Alley	\$ 39,594		36,994		2,600							
James A. Keller	\$ 97,265		20,493						65,419		11,353	
	\$ 682,982	\$ 49,892	\$ 117,843	\$ 101,840	\$ 134,300	\$ 24,065	\$ 6,000	\$ 24,030	\$ 129,373	\$ 43,279	\$ 11,353	\$ 41,007