

		FOR BHF USE				

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

HFS ID Number: 371082826001

Date of Initial License for Current Owners: 01/01/1972

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
IRS Exemption Code _____	<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) 833-5070x11

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Richard Stroh</u>	
	(Title) <u>Asst. Comptroller</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (____) _____	Fax # (____) _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	

Phone # (217) 782-1630

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	<u>25,821</u>	<u>90</u>		<u>25,911</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>25,821</u>	<u>90</u>		<u>25,911</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.74%

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

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

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

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

None

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

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

YES NO

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

YES NO

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

Date started 01/01/1972

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

YES Date _____ NO

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 01/01/06 Ending: 12/31/06

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
	A. General Services										
1	Dietary	125,424	7,825	8,376	141,625		141,625		141,625		1
2	Food Purchase		165,540		165,540		165,540		165,540		2
3	Housekeeping		20,094	2,793	22,887		22,887	332	23,219		3
4	Laundry		11,549	94	11,643		11,643		11,643		4
5	Heat and Other Utilities			68,711	68,711		68,711	1,214	69,925		5
6	Maintenance	48,477	17,019	6,072	71,568		71,568	26,160	97,728		6
7	Other (specify):*										7
8	TOTAL General Services	173,901	222,027	86,046	481,974		481,974	27,706	509,680		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	892,361	35,374	2,922	930,657		930,657	4,661	935,318		10
10a	Therapy		4,940	20,485	25,425		25,425		25,425		10a
11	Activities			823	823		823		823		11
12	Social Services	33,753	10,789	7,560	52,102		52,102	(6,316)	45,786		12
13	CNA Training	48,897		6,125	55,022		55,022		55,022		13
14	Program Transportation		7,345	4,125	11,470		11,470	1,805	13,275		14
15	Other (specify):* Day Training			645,735	645,735		645,735	(645,735)			15
16	TOTAL Health Care and Programs	975,011	58,448	694,975	1,728,434		1,728,434	(645,585)	1,082,849		16
	C. General Administration										
17	Administrative	173,856			173,856		173,856	22,766	196,622		17
18	Directors Fees							2,621	2,621		18
19	Professional Services			125,393	125,393		125,393	(119,583)	5,810		19
20	Dues, Fees, Subscriptions & Promotions			11,260	11,260		11,260	(3,107)	8,153		20
21	Clerical & General Office Expenses	42,885	11,438	16,030	70,353		70,353	32,366	102,719		21
22	Employee Benefits & Payroll Taxes			236,865	236,865		236,865	19,892	256,757		22
23	Inservice Training & Education			1,871	1,871		1,871		1,871		23
24	Travel and Seminar			215	215		215	463	678		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			10,811	10,811		10,811	788	11,599		26
27	Other (specify):*										27
28	TOTAL General Administration	216,741	11,438	402,445	630,624		630,624	(43,794)	586,830		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,365,653	291,913	1,183,466	2,841,032		2,841,032	(661,673)	2,179,359		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: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 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	
	D. Ownership											
30	Depreciation			19,602	19,602		19,602	4,976	24,578			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,196	3,196		3,196	(3,196)				32
33	Real Estate Taxes			31,299	31,299		31,299	(1,550)	29,749			33
34	Rent-Facility & Grounds			330,000	330,000		330,000	(327,626)	2,374			34
35	Rent-Equipment & Vehicles			92	92		92	1,025	1,117			35
36	Other (specify):* See Pg 25			16,182	16,182		16,182	(16,181)	1			36
37	TOTAL Ownership			400,371	400,371		400,371	(342,552)	57,819			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			128,439	128,439		128,439		128,439			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			128,439	128,439		128,439		128,439			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,365,653	291,913	1,712,276	3,369,842		3,369,842	(1,004,225)	2,365,617			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: 01/01/06

Ending: 12/31/06

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	\$ (645,735)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(691)	22		4
5	Telephone, TV & Radio in Resident Rooms	(400)	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	5,892	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	(3,196)	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				18
19	Entertainment				19
20	Contributions	(2,351)	20		20
21	Owner or Key-Man Insurance	(246)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,671)	36		24
25	Fund Raising, Advertising and Promotional	(666)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(264)	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(10,729)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (674,057)		\$	30

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)	(330,168)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (330,168)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,004,225)		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	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Mulberry Manor

ID# 0025411
 Report Period Beginning: 01/01/06
 Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Late Fees	\$ (95)	20	1
2	Chamber Deus	(144)	20	2
3	Flowers	(1,274)	12	3
4				4
5	Cigarettes	(458)	12	5
6	Christmas/clothing/personal	(3,184)	12	6
7				7
8	Gifts to Consultants	(1,000)	12	8
9	Non-Care Related Depreciation	(2,476)	30	9
10	R/E Taxes on Rental Property	(2,098)	33	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,729)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

01/01/06

Ending:

12/31/06**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	332	0	0	0	0	0	0	0	0	0	332	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	1,214	0	0	0	0	0	0	0	0	0	1,214	5
6	Maintenance	0	1,593	24,567	0	0	0	0	0	0	0	0	26,160	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	3,139	24,567	0	0	0	0	0	0	0	0	27,706	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	4,661	0	0	0	0	0	0	0	0	4,661	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	(6,316)	0	0	0	0	0	0	0	0	0	0	(6,316)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	1,805	0	0	0	0	0	0	0	0	0	1,805	14
15	Other (specify):*	(645,735)	0	0	0	0	0	0	0	0	0	0	(645,735)	15
16	TOTAL Health Care and Programs	(652,051)	1,805	4,661	0	0	0	0	0	0	0	0	(645,585)	16
	C. General Administration													
17	Administrative	0	0	22,766	0	0	0	0	0	0	0	0	22,766	17
18	Directors Fees	0	2,621	0	0	0	0	0	0	0	0	0	2,621	18
19	Professional Services	0	417	(120,000)	0	0	0	0	0	0	0	0	(119,583)	19
20	Fees, Subscriptions & Promotions	(3,256)	149	0	0	0	0	0	0	0	0	0	(3,107)	20
21	Clerical & General Office Expenses	0	5,613	26,753	0	0	0	0	0	0	0	0	32,366	21
22	Employee Benefits & Payroll Taxes	(691)	20,583	0	0	0	0	0	0	0	0	0	19,892	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	463	0	0	0	0	0	0	0	0	0	463	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	788	0	0	0	0	0	0	0	0	0	788	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,947)	30,634	(70,481)	0	0	0	0	0	0	0	0	(43,794)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(655,998)	35,578	(41,253)	0	0	0	0	0	0	0	0	(661,673)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning:

01/01/06 Ending:

12/31/06

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	3,416	1,560	0	0	0	0	0	0	0	0	0	4,976	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,196)	0	0	0	0	0	0	0	0	0	0	(3,196)	32
33	Real Estate Taxes	(2,098)	548	0	0	0	0	0	0	0	0	0	(1,550)	33
34	Rent-Facility & Grounds	0	0	(327,626)	0	0	0	0	0	0	0	0	(327,626)	34
35	Rent-Equipment & Vehicles	0	0	1,025	0	0	0	0	0	0	0	0	1,025	35
36	Other (specify):*	(16,181)	0	0	0	0	0	0	0	0	0	0	(16,181)	36
37	TOTAL Ownership	(18,059)	2,108	(326,601)	0	(342,552)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(674,057)	37,686	(367,854)	0	(1,004,225)	45							

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

01/01/06

Ending:

12/31/06

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
Jo Ann Keller	50	Pilot House	Cairo	kel-Tech Mgmt Co.	Anna	Accting Service
James K.Keller	50	Holly Hill	Anna	JR's Centre, Inc.	Anna	Workshop
		Lincoln Square	Jonesboro	ILS 1-3	Anna	CILA
		Glen Brook	Vienna	ILS 4	Metropolis	CILA
		Krypton	Metropolis			
		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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3 Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 332	\$ 332	1
2	V	5 Utilities		kel-Tech Management Co.	25.00%	1,214	1,214	2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	1,593	1,593	3
4	V	14 Transportation		kel-Tech Management Co.	25.00%	1,805	1,805	4
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	2,621	2,621	5
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	417	417	6
7	V	20 Dues, Fees, Subscription		kel-Tech Management Co.	25.00%	149	149	7
8	V	21 Clerical & General Office		kel-Tech Management Co.	25.00%	5,613	5,613	8
9	V	22 Employee Benefits & Taxes		kel-Tech Management Co.	25.00%	20,583	20,583	9
10	V	24 Inservice Training		kel-Tech Management Co.	25.00%	463	463	10
11	V	26 Insurance		kel-Tech Management Co.	25.00%	788	788	11
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	548	548	12
13	V	30 Depreciation		kel-Tech Management Co.	25.00%	1,560	1,560	13
14	Total		\$			\$ 37,686	\$ * 37,686	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	34	Rent	\$	kel-Tech Management Co.	25.00%	\$ 2,374	\$ 2,374	15
16	V	35	Equipment Rental		kel-Tech Management Co.	25.00%	1,025	1,025	16
17	V	10	Nursing		kel-Tech Management Co.	25.00%	4,661	4,661	17
18	V	17	Administration		kel-Tech Management Co.	25.00%	22,766	22,766	18
19	V	21	Clerical		kel-Tech Management Co.	25.00%	26,753	26,753	19
20	V	6	Maintenance		kel-Tech Management Co.	25.00%	24,567	24,567	20
21	V								21
22	V	19	Professional Services	120,000	kel-Tech Management Co.	25.00%		(120,000)	22
23	V	34	Building Lease	330,000	J & J Partners	100.00%		(330,000)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 450,000				\$ 82,146	\$ * (367,854)	39

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

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	Jo Ann Keller	Owner/Admin	Administrator	50.00	23,994	32	80.00	Admin. Wage	\$ 102,575	17-1	1
2	Diana Alley	Asst. Administrator	Nursing	0.00	36,110	5	12.50	Admin. Wage	15,647	17-1	2
3	Densie Pippins	Asst. Administrator	Administrator	0.00	26,149	5	12.50	Admin. Wage	12,170	17-1	3
4	James K. Keller	Owner	Maintenance	50.00	0	10	25.00	Maint. Wages	14,543	6-1	4
5	Ashlee Alley		Clerical	0.00	0	10	25.00	Clerical Wages	18,227	21-1	5
6											6
7	kel-Tech Management Allocation										7
8	James A. Keller							Admin. Wage	22,768		8
9	Jacob Alley							Maint. Wages	17,489		9
10	Diana Alley							Nursing Wages	4,662		10
11											11
12											12
13								TOTAL	\$ 208,081		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: 01/01/06 Ending: 12/31/06

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 Mgmt 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 Contribution	363,999	12	\$ 1,008	\$ 120,000	\$ 332	1
2	5	UTILITIES ELECT/GAS-B	Mgmt Fee Contribution	363,999	12	3,312	120,000	1,092	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	363,999	12	369	120,000	122	3
4	6	GROUNDS MAINT-B	Mgmt Fee Contribution	363,999	12	498	120,000	164	4
5	6	MAINTENANCE SUPPLIES-B	Mgmt Fee Contribution	363,999	12	748	120,000	247	5
6	6	MAINTENANCE VEHICLE	Mgmt Fee Contribution	363,999	12	292	120,000	96	6
7	6	PREVENTATIVE MAINT-B	Mgmt Fee Contribution	363,999	12	1,474	120,000	486	7
8	6	REPAIRS BLDG-B	Mgmt Fee Contribution	363,999	12	284	120,000	94	8
9	6	REPAIRS FURN/EQUIP-B	Mgmt Fee Contribution	363,999	12	1,536	120,000	506	9
10	14	REPAIRS VEHICLES-B	Mgmt Fee Contribution	363,999	12	721	120,000	238	10
11	14	TRANSPORTATION-B	Mgmt Fee Contribution	363,999	12	4,754	120,000	1,567	11
12	18	DIRECTOR'S FEES	Mgmt Fee Contribution	363,999	12	7,950	120,000	2,621	12
13	19	CONTRACT SERVICES	Mgmt Fee Contribution	363,999	12	455	120,000	150	13
14	19	LEGAL & ACCOUNTING-B	Mgmt Fee Contribution	363,999	12	810	120,000	267	14
15	20	DUES FEES SUBSCRIPTIONS-B	Mgmt Fee Contribution	363,999	12	452	120,000	149	15
16	21	EDUCATIONAL SUPPLIES-B	Mgmt Fee Contribution	363,999	12	144	120,000	48	16
17	21	BANK CHARGES-B	Mgmt Fee Contribution	363,999	12	0	120,000	0	17
18	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contribution	363,999	12	122	120,000	40	18
19	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	363,999	12	191	120,000	63	19
20	21	G & A MISC-B	Mgmt Fee Contribution	363,999	12	288	120,000	95	20
21	21	G & A MISC-B:88210 · SUPPLIE	Mgmt Fee Contribution	363,999	12	158	120,000	52	21
22	21	G & A SUPPLIES-B	Mgmt Fee Contribution	363,999	12	7,730	120,000	2,548	22
23	21	POSTAGE-B	Mgmt Fee Contribution	363,999	12	3,086	120,000	1,017	23
24	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	363,999	12	891	120,000	294	24
25	TOTALS					\$ 37,273	\$	\$ 12,288	25

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Mgmt 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	TELEPHONE-B	Mgmt Fee Contribution	363,999	12	\$ 2,367	\$ 120,000	\$ 780	1	
2	21	CELL PHONE EXPENSE	Mgmt Fee Contribution	363,999	12	1,641	120,000	541	2	
3	21	UTILITIES-INTERNET	Mgmt Fee Contribution	363,999	12	408	120,000	135	3	
4	22	INS EMP GROUP-B	Mgmt Fee Contribution	363,999	12	40,061	120,000	13,207	4	
5	22	INSURANCE W/C-B	Mgmt Fee Contribution	363,999	12	2,664	120,000	878	5	
6	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	363,999	12	19,708	120,000	6,497	6	
7	24	ADM. STAFF TRAINING	Mgmt Fee Contribution	363,999	12	1,406	120,000	463	7	
8	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	363,999	12	1,145	120,000	377	8	
9	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	363,999	12	1,246	120,000	411	9	
10	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	363,999	12	1,661	120,000	548	10	
11	30	DEPRECIATION	Mgmt Fee Contribution	363,999	12	4,731	120,000	1,560	11	
12	34	LEASE BLDG-B	Mgmt Fee Contribution	363,999	12	7,200	120,000	2,374	12	
13	35	LEASE EQUIP-B	Mgmt Fee Contribution	363,999	12	3,110	120,000	1,025	13	
14	10	Nursing	Mgmt Fee Contribution	363,999	12	14,140	14,140	120,000	4,662	14
15	17	Administration	Mgmt Fee Contribution	363,999	12	69,058	69,058	120,000	22,766	15
16	21	Clerical	Mgmt Fee Contribution	363,999	12	81,149	81,149	120,000	26,753	16
17	6	Maintenance	Mgmt Fee Contribution	363,999	12	74,519	74,519	120,000	24,567	17
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 326,215	\$ 238,866	\$ 107,544	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										6										
7										7										
8										8										
9	TOTAL Facility Related									9										
B. Non-Facility Related*																				
10	Capaha Bank		X	Rental House Purchase	\$707.84	3/3/04	63,500	49,687	3/3/09	6.0000	3,196	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related				\$707.84		\$ 63,500	\$ 49,687			\$ 3,196	14								
15	TOTALS (line 9+line14)						\$ 63,500	\$ 49,687			\$ 3,196	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:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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.

2005 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 x11 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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>1,482.10</u>	\$ <u>1,482.10</u>
2. <u>05-20-03-682</u>	<u>S PT W 1/2 SE S of RD</u>	\$ <u>23,387.98</u>	\$ <u>23,387.98</u>
3. <u>05-20-03-683</u>	<u>S PT W 1/2 SE S of RD</u>	\$ <u>1,721.08</u>	\$ <u>1,721.08</u>
4. <u>05-20-03-679</u>	<u>S20 T12 R1W W PT S PT W 1/2 SE S</u>	\$ <u>2,097.98</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>28,689.14</u>	\$ <u>26,591.16</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,715 B. General Construction Type: Exterior Brick/block Frame Metal Stud Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	46		1972		\$ 172,058	\$	30	\$	\$	\$	4
5	28		1975		151,678		27				5
6	6		1979		4,663		23				6
7			1987		40,400		15				7
8					16,300		30	543	543		8
	Improvement Type**										
9	Gazebo		1986		2,561		5			2,561	9
10	Laundry Room		1990		18,146	576	31.5	454	(122)	9,469	10
11	Landscaping		1990		505		15			505	11
12	Central Air Conditioning		1990		9,323		10	466	466	9,323	12
13	Blue House Improvements		1991		4,817	153	31.5	120	(33)	2,328	13
14	Blacktop Driveway		1992		3,260	192	15	163	(29)	3,159	14
15	New Roof		1992		8,055	475	15	403	(72)	7,812	15
16	Livingroom Remodel		1992		1,203	71	15	60	(11)	1,167	16
17	Seamless Gutters		1993		1,536	91	15	77	(14)	1,402	17
18	A/C & Heaters		1993		8,823	521	15	441	(80)	8,041	18
19	Dining Room Improvements		1995		9,127	609	15	456	(153)	6,775	19
20	Bath Carpet & Fencing		1995		4,428	295	15	295		3,097	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)	10,751	22
23	Smoking Room Equipment		1998		952		7	95	95	952	23
24	C-Wing Air Conditioning		1998		2,446	163	15	163		1,385	24
25	Kitchen Cabnets		1998		779		7	78	78	779	25
26	Office Air Conditioning		1998		1,059	71	15	71		603	26
27	Storage Building		1999		3,857	257	15	257		1,927	27
28	Water Garden		2001		2,922	195	15	195		999	28
29	A/C Comptessor		2001		1,027	69	15	68	(1)	388	29
30	Fire Suplestion System		2003		1,716	80	15	114	34	795	30
31	Jo Ann Office Remodel		2003		8,543	399	15	570	171	3,959	31
32	A/C Unit Laundry Room		2003		1,068	36	15	71	35	660	32
33	Furnace Blue House		2004		2,213	95	15	148	53	1,362	33
34	Stopper II Fire Alarm		2004		637		7	91	91	637	34
35	Vinyl Fence		2004		5,350	229	15	357	128	3,292	35
36	Roof Mount A/C Unit		2004		2,473	106	15	165	59	1,522	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:

01/01/06 Ending:

12/31/06

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	Vinyl Windows	2005	\$ 411	\$ 27	15	\$ 27	\$	\$ 41	37
38	Carpet Office	2006	954	954	7	102	(852)	954	38
39	Flooring - Blue House	2006	1,397	12	15	16	4	12	39
40	Lumber Blue House	2006	1,742	14	15	10	(4)	14	40
41	Drainage System	2006	8,909	74	15	49	(25)	74	41
42	Base Board & Carpet	2006	96	96	7	1	(95)	96	42
43	Rest Room Remodeling	1988	10,790		15	540	540	10,790	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)		\$ 564,300	\$ 7,049		\$ 7,994	\$ 945	\$ 99,315	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: 01/01/06 Ending: 12/31/06

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	\$ 385	\$ 1,185	\$ 800	7	\$ 6,674	71
72	Current Year Purchases	9,692	9,692	3,409	(6,283)	7	9,692	72
73	Fully Depreciated Assets	139,033		10,430	10,430	7	139,033	73
74								74
75	TOTALS	\$ 156,552	\$ 10,077	\$ 15,024	\$ 4,947		\$ 155,399	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)	\$ 813,106	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,126	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 23,018	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,892	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 335,581	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental Property	\$ 68,244	\$ 2,476	\$ 7,097	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 68,244	\$ 2,476	\$ 7,097	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Related Party

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

If NO, see instructions.

YES NO

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

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: \$ 92

Description: Oxygen Tank Rental

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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)	1,854	5,625		7,479
4	Clinical Wages (b)	3,615	10,969		14,584
5	In-House Trainer Wages (c)	6,651	20,183		26,834
6	Transportation				
7	Contractual Payments	2,695	3,430		6,125
8	CNA Competency Tests				
9	TOTALS	\$ 14,815	\$ 40,207	\$	\$ 55,022
10	SUM OF line 9, col. 1 and 2 (e)	\$ 55,022			

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	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	12
2. From other facilities (f)	
TOTAL TRAINED	31

- (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:01/01/06 Ending:12/31/06

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	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.

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 457,978	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	645,616		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	113		7
8	Accounts Receivable (owners or related parties)	1,761,955		8
9	Other(specify): <u>Fed & State Inc. Tax Refundable</u>	220,800		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,086,462	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	64,013		14
15	Leasehold Improvements, at Historical Cost	171,503		15
16	Equipment, at Historical Cost	238,558		16
17	Accumulated Depreciation (book methods)	(333,769)		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): <u>DSP Training Reimbursable</u>	8,073		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 148,378	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,234,840	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,332	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	200,000		29
30	Accrued Salaries Payable	57,812		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,850		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,410		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 301,404	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	49,687		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)	\$ 49,687	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 351,091	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,883,749	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,234,840	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,794,363	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,794,363	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	89,386	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)	\$ 89,386	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,883,749	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 01/01/06Ending: 12/31/06**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,762,249	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,762,249	3
B. Ancillary Revenue			
4	Day Care	645,735	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 645,735	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	27,554	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	1,600	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)	\$ 29,154	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	22,090	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,090	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,459,228	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	481,974	31
32	Health Care	1,728,434	32
33	General Administration	630,624	33
B. Capital Expense			
34	Ownership	400,371	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	128,439	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,369,842	40
41	Income before Income Taxes (line 30 minus line 40)**	89,386	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 89,386	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:

01/01/06

Ending:

12/31/06

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	2,045	2,085	\$ 43,679	\$ 20.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,871	11,216	151,826	13.54	3
4	Licensed Practical Nurses					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					10
11	Social Service Workers	3,263	3,399	33,753	9.93	11
12	Dietician					12
13	Food Service Supervisor	13,502	13,943	125,424	9.00	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,989	2,149	48,477	22.56	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	4,279	4,416	173,856	39.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,949	3,013	42,885	14.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,996	4,075	48,992	12.02	28
29	Resident Services Coordinator	81,199	83,355	696,761	8.36	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	124,093	127,651	\$ 1,365,653 *	\$ 10.70	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	188	\$ 8,376	1-3	35
36	Medical Director	96	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	1,500	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	171	4,275	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	216	7,560	12-3	45
46	Other(specify) <u>Dental Consultant</u>	15	1,100	10a-3	46
47	<u>See Page 25</u>	188	14,114		47
48					48
49	TOTAL (lines 35 - 48)	922	\$ 44,125		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? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,554 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. \$ 128,439
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. \$ 691 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ 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 \$5,000, 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.

Related Parties Schedule VII
 Owners Compensation
 Jan 1, 2006 - Dec 31, 2006

	Totals / Entity	Holly Hill	ILS 1-4	JR's Centre	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook	New Way
Don Pippins	\$ 110,449	23,871		3,462					43,171		39,945
Denise Pippins	\$ 70,869	26,149	7,500	25,050	12,170						
Diana Alley	\$ 111,497	12,015	36,000	9,600	15,647		24,095	14,140			
Jo Ann Keller	\$ 145,069			18,500	102,575	23,994					
James K. Keller	\$ 32,543			18,000	14,543						
Jacob Alley	\$ 53,045							53,045			
Jake Alley	\$ 37,527		37,527								
James A. Keller	\$ 100,019		20,150					69,058		10,811	
	\$ 661,018	\$ 62,035	\$ 101,178	\$ 74,612	\$ 144,935	\$ 23,994	\$ 24,095	\$ 136,243	\$ 43,171	\$ 10,811	\$ 39,945

Mulberry Manor, Inc.
Detail Sch. XVIII, B.
2006

	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
Psychiatric Consultant	80	\$ 6,000	10a-3
Psychologist Consultant	44	3,320	10a-3
Behavioral Consultant	64	4,794	10a-3
Total	188	\$ 14,114	

Mulberry Manor, Inc.
Sch. V, Line 20, Col. 8
Analysis of Dues, Fees & Subscriptions
2006

Subscriptions	\$ 886
Memberships	
Arc of IL	25
IL Guardianship Assoc.	500
MIES of IL	798
Sam's Club	70
Chamber Dues	144
PO Box Rental	138
Resident Account Bond	900
CLIA Lab Certification	150
Corp. Annual Report	100
Advertising Help Wanted	2,597
Advertising	666
Late Fees	95
Contributions	2,351
Less	
Chamber Dues	(144)
Advertising	(666)
Late Fees	(95)
Contributions	(2,351)
	<u>\$ 6,164</u>

Mulberry Manor, Inc.
Reconciliation Sch. XI, Col. 6, Line 83 to
Sch. V, Line 30, Col. 8
2006

Sch. XI, Col. 6, Line 83	\$ 23,018
kel-Tech Mgmt Allocation	1,560
Sch. V, Line 30, Col. 8	<u>\$ 24,578</u>

Mulberry Manor, Inc.
Sch. V Line 36, Col. 4
2006

Bad Debt	\$ 15,671
Insurance - Officers's Life	246
State Income Tax	265
Total	<u>\$ 16,182</u>

Mulberry Manor, Inc.
Reconciliation of Book to Tax
Sch XVII
2006

Adjusted Book Income	\$ 89,386
Adjustment for accrual, 2006	(668,519)
Adjustment for non-deductible exp.:	
Officers' Life Insurance	246
Wage Credit offset against wage exp.	4,248
Section 179 depreciation carryover	10,742
Charitable contribution carryover	2,351
Add provision for federal Inc. Tax refundable	276,568
	<u>\$ (284,978)</u>

Mulberry Manor, Inc.
Sch. XX, Question 14; Schedule of Costs
2006

Rental Property Costs Paid by Mulberry Manor

Interest Expense	\$ 3,196
R/E Tax Expense	2,098
Depreciation Expense	2,476
Total	<u>\$ 7,770</u>