

		FOR BHF USE				

LL1

2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0025411

Facility Name: Mulberry Manor

Address: 612 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 1/1/07 to 12/31/07 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: 1/1/07 Ending: 12/31/07

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	<u>80</u>	Intermediate/DD	<u>80</u>	<u>29,200</u>	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			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>27,641</u>			<u>27,641</u>
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>27,641</u>			<u>27,641</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.66%

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

310 (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)

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

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

YES NO

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

YES NO

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

Date started 01/01/1972

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

YES Date _____ NO

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

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

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	126,826	6,423	8,241	141,490		141,490		141,490		1
2	Food Purchase		179,184		179,184		179,184		179,184		2
3	Housekeeping	78,909	21,091		100,000		100,000	381	100,381		3
4	Laundry		10,245	90	10,335		10,335		10,335		4
5	Heat and Other Utilities			86,888	86,888		86,888	583	87,471		5
6	Maintenance	48,102	12,414	8,595	69,111		69,111	19,451	88,562		6
7	Other (specify):*										7
8	TOTAL General Services	253,837	229,357	103,814	587,008		587,008	20,415	607,423		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	966,884	39,231	10,473	1,016,588		1,016,588	4,641	1,021,229		10
10a	Therapy		5,297	23,592	28,889		28,889		28,889		10a
11	Activities	24,049		2,397	26,446		26,446		26,446		11
12	Social Services		10,110	8,510	18,620		18,620	(5,412)	13,208		12
13	CNA Training	30,638		6,125	36,763		36,763		36,763		13
14	Program Transportation		7,147	5,210	12,357		12,357	1,887	14,244		14
15	Other (specify):* Day Training			770,402	770,402		770,402	(770,402)			15
16	TOTAL Health Care and Programs	1,021,571	61,785	833,909	1,917,265		1,917,265	(769,286)	1,147,979		16
	C. General Administration										
17	Administrative	183,395			183,395		183,395	22,588	205,983		17
18	Directors Fees							2,640	2,640		18
19	Professional Services			130,392	130,392		130,392	(119,559)	10,833		19
20	Dues, Fees, Subscriptions & Promotions			14,745	14,745		14,745	(6,237)	8,508		20
21	Clerical & General Office Expenses	41,411	9,061	12,374	62,846		62,846	39,816	102,662		21
22	Employee Benefits & Payroll Taxes			220,001	220,001		220,001	17,213	237,214		22
23	Inservice Training & Education			191	191		191		191		23
24	Travel and Seminar			210	210		210	206	416		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			13,956	13,956		13,956	773	14,729		26
27	Other (specify):*										27
28	TOTAL General Administration	224,806	9,061	391,869	625,736		625,736	(42,560)	583,176		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,500,214	300,203	1,329,592	3,130,009		3,130,009	(791,431)	2,338,578		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: 1/1/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			26,633	26,633	26,633	11,932	38,565			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			4,979	4,979	4,979	(4,979)				32
33	Real Estate Taxes			32,779	32,779	32,779	(1,657)	31,122			33
34	Rent-Facility & Grounds			330,000	330,000	330,000	(327,696)	2,304			34
35	Rent-Equipment & Vehicles			742	742	742	894	1,636			35
36	Other (specify):* See Pg. 25			(89,532)	(89,532)	(89,532)	89,531	(1)			36
37	TOTAL Ownership			305,601	305,601	305,601	(231,975)	73,626			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			220,747	220,747	220,747		220,747			42
43	Other (specify):* Rental Expenses			2,699	2,699	2,699	(2,699)				43
44	TOTAL Special Cost Centers			223,446	223,446	223,446	(2,699)	220,747			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,500,214	300,203	1,858,639	3,659,056	3,659,056	(1,026,105)	2,632,951			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: 1/1/07

Ending: 12/31/07

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (770,402)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(488)	22		4
5	Telephone, TV & Radio in Resident Rooms	(513)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,663	30		9
10	Interest and Other Investment Income	(4,979)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(2,493)	43		15
16	Personal Expenses (Including Transportation)	(500)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(29)	36		18
19	Entertainment				19
20	Contributions	(4,150)	20		20
21	Owner or Key-Man Insurance	(185)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,620)	36		24
25	Fund Raising, Advertising and Promotional	(2,050)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	93,365	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg 5A	(8,011)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (701,392)		\$	30

BHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(324,713)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (324,713)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,026,105)		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

Mulberry Manor

ID# 0025411
 Report Period Beginning: 1/1/07
 Ending: 12/31/07

Sch. V Line
 Reference

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Chamber Dues,NFIB Dues	\$ (150)	20	1
2	Flowers	(710)	12	2
3	Cigarettes	(989)	12	3
4	Christmas/Clothing/Personal	(3,713)	12	4
5	Non - Care Related R/E Taxes	(2,243)	33	5
6	Non - Care Rental Expenses	(206)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,011)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	381	0	0	0	0	0	0	0	0	0	381	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(513)	1,096	0	0	0	0	0	0	0	0	0	583	5
6	Maintenance	0	1,549	17,902	0	0	0	0	0	0	0	0	19,451	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(513)	3,026	17,902	0	20,415	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	4,641	0	0	0	0	0	0	0	0	4,641	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	(5,412)	0	0	0	0	0	0	0	0	0	0	(5,412)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	1,887	0	0	0	0	0	0	0	0	0	1,887	14
15	Other (specify):*	(770,402)	0	0	0	0	0	0	0	0	0	0	(770,402)	15
16	TOTAL Health Care and Programs	(775,814)	1,887	4,641	0	(769,286)	16							
	C. General Administration													
17	Administrative	0	0	22,588	0	0	0	0	0	0	0	0	22,588	17
18	Directors Fees	0	2,640	0	0	0	0	0	0	0	0	0	2,640	18
19	Professional Services	0	441	(120,000)	0	0	0	0	0	0	0	0	(119,559)	19
20	Fees, Subscriptions & Promotions	(6,350)	113	0	0	0	0	0	0	0	0	0	(6,237)	20
21	Clerical & General Office Expenses	(500)	5,335	34,981	0	0	0	0	0	0	0	0	39,816	21
22	Employee Benefits & Payroll Taxes	(488)	17,701	0	0	0	0	0	0	0	0	0	17,213	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	206	0	0	0	0	0	0	0	0	0	206	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	773	0	0	0	0	0	0	0	0	0	773	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(7,338)	27,209	(62,431)	0	(42,560)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(783,665)	32,122	(39,888)	0	(791,431)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning:

1/1/07 Ending:

12/31/07

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	2,663	9,269	0	0	0	0	0	0	0	0	0	11,932	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,979)	0	0	0	0	0	0	0	0	0	0	(4,979)	32
33	Real Estate Taxes	(2,243)	586	0	0	0	0	0	0	0	0	0	(1,657)	33
34	Rent-Facility & Grounds	0	0	(327,696)	0	0	0	0	0	0	0	0	(327,696)	34
35	Rent-Equipment & Vehicles	0	0	894	0	0	0	0	0	0	0	0	894	35
36	Other (specify):*	89,531	0	0	0	0	0	0	0	0	0	0	89,531	36
37	TOTAL Ownership	84,972	9,855	(326,802)	0	(231,975)	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):*	(2,699)	0	0	0	0	0	0	0	0	0	0	(2,699)	43
44	TOTAL Special Cost Centers	(2,699)	0	0	0	0	0	0	0	0	0	0	(2,699)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(701,392)	41,977	(366,690)	0	(1,026,105)	45							

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

1/1/07

Ending:

12/31/07

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	3 Housekeeping	\$	kel-Tech Management Co.	25.00%	\$ 381	\$	381	1
2	V	5 Utilities		kel-Tech Management Co.	25.00%	1,096		1,096	2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	1,549		1,549	3
4	V	14 Transportation		kel-Tech Management Co.	25.00%	1,887		1,887	4
5	V	18 Director's Fees		kel-Tech Management Co.	25.00%	2,640		2,640	5
6	V	19 Professional Services		kel-Tech Management Co.	25.00%	441		441	6
7	V	20 Due, Fees, Subscriptions		kel-Tech Management Co.	25.00%	113		113	7
8	V	21 Clerical & General Office		kel-Tech Management Co.	25.00%	5,335		5,335	8
9	V	22 Employee Ben & Taxes		kel-Tech Management Co.	25.00%	17,701		17,701	9
10	V	24 Inservice Training		kel-Tech Management Co.	25.00%	206		206	10
11	V	26 Insurance		kel-Tech Management Co.	25.00%	773		773	11
12	V	30 Depreciation		kel-Tech Management Co.	25.00%	9,269		9,269	12
13	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	586		586	13
14	Total		\$ 2,304			\$ 41,977	\$ *	41,977	14

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

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning: 1/1/07

Ending: 12/31/07

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%	\$ 2,304	\$ 2,304	15
16	V	35	Equipment Rental		kel-Tech Management Co.	25.00%	894	894	16
17	V	10	Nursing Wages		kel-Tech Management Co.	25.00%	4,641	4,641	17
18	V	17	Admin Wages		kel-Tech Management Co.	25.00%	22,588	22,588	18
19	V	21	Clerical Wages		kel-Tech Management Co.	25.00%	34,981	34,981	19
20	V	6	Maintenance Wages		kel-Tech Management Co.	25.00%	17,902	17,902	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				\$ 83,310	\$ * (366,690)	39

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

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/07 Ending: 12/31/07

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	24,027	32	80.00	Admin. Wage	\$ 121,258	17-1	1
2	Diana Alley	Asst. Administrator	Nursing	0.00	41,296	5	12.50	Admin. Wage	14,976	17-1	2
3	James K. Keller	Owner	Maintenance	50.00		10	25.00	Maint. Wages	14,400	6-1	3
4											4
5											5
6											6
7	kel-Tech Management Allocation										7
8	James A. Keller							Admin. Wage	22,588	17-1	8
9	Jacob Alley							Maint. Wages	17,436	6-1	9
10	Diana Alley							Nursing Wages	4,641	10-1	10
11											11
12											12
13								TOTAL	\$ 195,299		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:

1/1/07Ending: 12/31/07

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	374,996	10	\$ 1,192	\$ 120,000	\$ 381	1
2	5	UTILITIES ELECT/GAS-B	Mgmt Fee Contribution	374,996	10	3,077	120,000	985	2
3	5	UTILITIES WATER-B	Mgmt Fee Contribution	374,996	10	349	120,000	112	3
4	6	GROUNDS MAINT-B	Mgmt Fee Contribution	374,996	10	537	120,000	172	4
5	6	MAINT BUILDING	Mgmt Fee Contribution	374,996	10	36	120,000	11	5
6	6	MAINTENANCE MISC-B	Mgmt Fee Contribution	374,996	10	225	120,000	72	6
7	6	MAINTENANCE SUPPLIES-B	Mgmt Fee Contribution	374,996	10	572	120,000	183	7
8	6	PREVENTATIVE MAINT-B	Mgmt Fee Contribution	374,996	10	1,964	120,000	628	8
9	6	REPAIRS BLDG-B	Mgmt Fee Contribution	374,996	10	69	120,000	22	9
10	6	REPAIRS FURN/EQUIP-B	Mgmt Fee Contribution	374,996	10	1,438	120,000	460	10
11	14	MAINTENANCE VEHICLE	Mgmt Fee Contribution	374,996	10	141	120,000	45	11
12	14	REPAIRS VEHICLES-B	Mgmt Fee Contribution	374,996	10	1,310	120,000	419	12
13	14	TRANSPORTATION-B	Mgmt Fee Contribution	374,996	10	4,445	120,000	1,423	13
14	18	DIRECTOR'S FEES	Mgmt Fee Contribution	374,996	10	8,250	120,000	2,640	14
15	19	CONTRACT SERVICES-B	Mgmt Fee Contribution	374,996	10	552	120,000	177	15
16	19	LEGAL & ACCOUNTING-B	Mgmt Fee Contribution	374,996	10	825	120,000	264	16
17	20	ADV. HELP WANTED-B	Mgmt Fee Contribution	374,996	10	25	120,000	8	17
18	20	DUES FEES SUBSCRIPTIONS-B	Mgmt Fee Contribution	374,996	10	330	120,000	106	18
19	21	EDUCATIONAL SUPPLIES-B	Mgmt Fee Contribution	374,996	10	42	120,000	13	19
20	21	BANK CHARGES-B	Mgmt Fee Contribution	374,996	10	27	120,000	8	20
21	21	COPIER EXPENSE SUPPLIES	Mgmt Fee Contribution	374,996	10	692	120,000	221	21
22	21	COPIER EXPENSE SERVICE C	Mgmt Fee Contribution	374,996	10	93	120,000	30	22
23	21	G & A MISC-B	Mgmt Fee Contribution	374,996	10	524	120,000	168	23
24	21	SUPPLIES STOCK	Mgmt Fee Contribution	374,996	10	415	120,000	133	24
25	TOTALS					\$ 27,127	\$	\$ 8,681	25

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

1/1/07

Ending: 12/31/07

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	G & A SUPPLIES	Mgmt Fee Contribution	374,996	10	\$ 7,124	\$ 120,000	\$ 2,280	1	
2	21	POSTAGE-B	Mgmt Fee Contribution	374,996	10	2,828	120,000	905	2	
3	21	SOFTWARE EXPENSE	Mgmt Fee Contribution	374,996	10	971	120,000	311	3	
4	21	TELEPHONE-B	Mgmt Fee Contribution	374,996	10	2,041	120,000	653	4	
5	21	CELL PHONE EXPENSE	Mgmt Fee Contribution	374,996	10	1,506	120,000	482	5	
6	21	UTILITIES-INTERNET	Mgmt Fee Contribution	374,996	10	408	120,000	131	6	
7	22	INS EMP GROUP-B	Mgmt Fee Contribution	374,996	10	35,536	120,000	11,372	7	
8	22	INSURANCE W/C-B	Mgmt Fee Contribution	374,996	10	(559)	120,000	(179)	8	
9	22	PAYROLL TAX EXPENSE	Mgmt Fee Contribution	374,996	10	20,337	120,000	6,508	9	
10	24	ADM. STAFF TRAINING	Mgmt Fee Contribution	374,996	10	643	120,000	206	10	
11	26	INSURANCE BLDG & LIAB-B	Mgmt Fee Contribution	374,996	10	1,181	120,000	378	11	
12	26	INSURANCE VEHICLES-B	Mgmt Fee Contribution	374,996	10	1,234	120,000	395	12	
13	30	DEPRECIATION-B	Mgmt Fee Contribution	374,996	10	2,489	120,000	796	13	
14	30	DEPREC Sect 179	Mgmt Fee Contribution	374,996	10	26,475	120,000	8,472	14	
15	32	LEASE EQUIP-B	Mgmt Fee Contribution	374,996	10	2,795	120,000	894	15	
16	33	REAL ESTATE TAXES-B	Mgmt Fee Contribution	374,996	10	1,832	120,000	586	16	
17	34	LEASE BLDG-B	Mgmt Fee Contribution	374,996	10	7,200	120,000	2,304	17	
18	10	NURSING	Mgmt Fee Contribution	374,996	10	14,502	14,502	120,000	4,641	18
19	17	ADMINISTRATION	Mgmt Fee Contribution	374,996	10	70,587	70,587	120,000	22,588	19
20	21	CLERICAL	Mgmt Fee Contribution	374,996	10	109,315	109,315	120,000	34,981	20
21	6	MAINTENANCE	Mgmt Fee Contribution	374,996	10	55,944	55,944	120,000	17,902	21
22									22	
23									23	
24									24	
25	TOTALS					\$ 364,389	\$ 250,348	\$ 116,606	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	Citizen Auto Finance		X	Vehicle Loan	\$672.33	3/30/07	\$ 35,001	\$ 31,102	3/14/12	5.6400	\$ 1,478	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6	First National Bank of Jonesboro		X	Line of Credit			130,000			6.0000	408	6								
7												7								
8												8								
9	TOTAL Facility Related				\$672.33		\$ 165,001	\$ 31,102			\$ 1,886	9								
B. Non-Facility Related*																				
10	Capaha		X	Rental House Purchase	\$707.84	3/3/04	63,500	43,578	3/3/09	6.0000	3,093	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related				\$707.84		\$ 63,500	\$ 43,578			\$ 3,093	14								
15	TOTALS (line 9+line14)						\$ 228,501	\$ 74,680			\$ 4,979	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>1,584.92</u>	\$ <u>1,584.92</u>
2. <u>05-20-03-682</u>	<u>S PT W 1/2 SE S of RD</u>	\$ <u>25,005.40</u>	\$ <u>25,005.40</u>
3. <u>05-20-03-683</u>	<u>S PT W 1/2 SE S of RD</u>	\$ <u>1,841.08</u>	\$ <u>1,841.08</u>
4. <u>05-20-03-679</u>	<u>S20 T12 R1W W PT S PT W 1/2 SE S</u>	\$ <u>2,242.70</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>30,674.10</u>	\$ <u>28,431.40</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

1/1/07

Ending:

12/31/07

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:

1/1/07

Ending:

12/31/07

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)	10,045	10
11	Landscaping		1990		505		15			505	11
12	Central A/C		1990		9,323		10	466	466	9,323	12
13	Improvements - blue House		1991		4,817	153	31.5	120	(33)	2,481	13
14	Blacktop Driveway		1992		3,260	101	15	163	62	3,260	14
15	New Roof		1992		8,055	243	15	403	160	8,055	15
16	Remodeled Living Room		1992		1,203	36	15	60	24	1,203	16
17	Remodeling - Rest Rooms		1988		10,790		15	540	540	10,790	17
18	Seamless Gutters		1993		1,536	91	15	77	(14)	1,493	18
19	A/C & Heaters		1993		8,823	521	15	441	(80)	8,562	19
20	Dining Room Improvements		1995		9,127	609	15	456	(153)	7,384	20
21	Bath, Carpet & Fencing		1995		4,428	295	15	295		3,392	21
22	Carpet		1997		1,684		7	88	88	1,684	22
23	Smoking Room Addition		1997		46,392	1,189	39	1,160	(29)	11,940	23
24	Smoking Room Equipment		1998		952		7	95	95	952	24
25	A/C - C Wing		1998		2,446	163	15	163		1,548	25
26	Kitchen Cabnets		1998		779		7	78	78	779	26
27	A/C Office		1998		1,059	71	15	71		674	27
28	Storage Building		1999		3,857	257	15	257		2,184	28
29	Water Garden		2001		2,922	195	15	195		1,194	29
30	A/C Compressor		2001		1,027	69	15	68	(1)	457	30
31	Fire Supression System		2003		1,716	80	15	114	34	875	31
32	Jo ann's Office Remodel		2003		8,543	399	15	570	171	4,358	32
33	A/C Laundry Room		2003		1,068	36	15	71	35	696	33
34	Furnace - Blue House		2004		2,213	85	15	148	63	1,447	34
35	Stopper II Fire Alarm		2004		637		7	91	91	637	35
36	Vinyl Fence		2004		5,350	206	15	357	151	3,498	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:

1/1/07

Ending:

12/31/07

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 Unit Roof Mount	2004	\$ 2,473	\$ 95	15	\$ 165	\$ 70	\$ 1,617	37
38	Vinly Windows	2005	411	27	15	27		68	38
39	Carpet Office	2006	954		7	136	136	954	39
40	Flooring - Blue House	2006	1,397	93	15	93		105	40
41	Lumber - Blue House	2006	1,742	116	15	116		130	41
42	Drainage System	2006	8,909	594	15	594		668	42
43	Base Board - Carpet	2006	96		7	14	14	96	43
44	Door Alarm / Bumber Guard	2007	1,315	44	15	44		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)		\$ 565,615	\$ 6,344		\$ 8,733	\$ 2,389	\$ 105,659	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: 1/1/07 Ending: 12/31/07

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	\$ 282	\$ 960	\$ 678	7	\$ 6,956	71
72	Current Year Purchases	16,947	16,947	1,243	(15,704)	7	16,947	72
73	Fully Depreciated Assets	108,581		13,110	13,110	7	108,581	73
74								74
75	TOTALS	\$ 133,355	\$ 17,229	\$ 15,313	\$ (1,916)		\$ 132,484	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	1993 Ford Van	1993	\$ 25,942	\$	\$	\$	5	\$ 25,942	76
77	Healthcare	1997 Ford Van	1997	25,653				5	25,653	77
78	Healthcare	1998 Ford Van	1999	29,272				5	29,272	78
79	Healthcare	2007 Buick Terraza	2007	35,001	3,060	5,250	2,190	5	3,060	79
80	TOTALS			\$ 115,868	\$ 3,060	\$ 5,250	\$ 2,190		\$ 83,927	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)	\$ 826,225	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,633	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,296	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,663	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 322,070	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 - Building	\$ 59,013	\$ 2,146	\$ 8,137	86
87	Rental Prop. - Furniture & Fixtures	1,141	70	961	87
88	Rental Property - Improvements	5,961	277	2,374	88
89	Rental Property - Land	5,000			89
90					90
91	TOTALS	\$ 71,115	\$ 2,493	\$ 11,472	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: 1/1/07

Ending: 12/31/07

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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 742 Description: Medical Equipment 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)	2,279	2,802		5,081
4	Clinical Wages (b)	4,443	5,463		9,906
5	In-House Trainer Wages (c)	7,020	8,631		15,651
6	Transportation				
7	Contractual Payments	3,920	2,205		6,125
8	CNA Competency Tests				
9	TOTALS	\$ 17,662	\$ 19,101	\$	\$ 36,763
10	SUM OF line 9, col. 1 and 2 (e)	\$ 36,763			

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	<u>9</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>16</u>
2. From other facilities (f)	
TOTAL TRAINED	25

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

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

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

	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: 1/1/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 442,606	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	871,667		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,741,935		8
9	Other(specify): <u>DSP Training Reimbursable</u>	5,187		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,061,395	\$	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	175,689		15
16	Equipment, at Historical Cost	250,363		16
17	Accumulated Depreciation (book methods)	(322,751)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 167,314	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,228,709	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 65,992	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,412		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,757		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,515		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Memorial Fund</u>	475		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 171,181	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	74,679		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)	\$ 74,679	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 245,860	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,982,849	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,228,709	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,883,749	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,883,749	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	99,100	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)	\$ 99,100	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)	\$ 2,982,849	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 1/1/07Ending: 12/31/07**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	\$ 2,957,451	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,957,451	3
B. Ancillary Revenue			
4	Day Care	770,402	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 770,402	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	18,325	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,325	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	11,978	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 11,978	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)	\$ 3,758,156	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	587,008	31
32	Health Care	1,917,265	32
33	General Administration	625,736	33
B. Capital Expense			
34	Ownership	305,601	34
C. Ancillary Expense			
35	Special Cost Centers	2,699	35
36	Provider Participation Fee	220,747	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,659,056	40
41	Income before Income Taxes (line 30 minus line 40)**	99,100	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 99,100	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:

1/1/07

Ending:

12/31/07

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	2,005	2,085	\$ 45,081	\$ 21.62	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,040	2,080	32,956	15.84	3
4	Licensed Practical Nurses	7,454	7,534	109,185	14.49	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,369	2,458	24,049	9.78	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	13,206	13,448	126,826	9.43	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,005	2,109	48,102	22.81	17
18	Housekeepers	9,401	9,594	78,909	8.22	18
19	Laundry					19
20	Administrator	3,864	4,008	183,395	45.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,058	3,098	41,411	13.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,012	6,252	57,384	9.18	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	81,385	82,605	752,916	9.11	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,799	135,271	\$ 1,500,214 *	\$ 11.09	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	181	\$ 8,241	35
36	Medical Director	96	7,200	36
37	Medical Records Consultant			37
38	Nurse Consultant	14	500	38
39	Pharmacist Consultant	48	1,500	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	188	4,700	43
44	Activity Consultant			44
45	Social Service Consultant	243	8,510	45
46	Other(specify) <u>Behavior Therapist</u>	113	8,456	46
47	<u>Psychologist Consultant</u>	52	3,875	47
48	<u>Psychiatric Consultant</u>	80	6,000	48
49	TOTAL (lines 35 - 48)	1,015	\$ 48,982	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 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,228 Line 10-2
- (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. \$ 220,747
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 488 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Related Parties Schedule VII
 Owners Compensation
 Jan 1, 2007 - Dec 31, 2007

	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	\$ 114,498	31,229							43,269		40,000
Denise Pippins	\$ 26,029	26,029	-								
Diana Alley	\$ 70,774	18,781	14,502		14,976		22,515				
Jo Ann Keller	\$ 145,285				121,258	24,027					
James K. Keller	\$ 14,400				14,400						
Jacob Alley	\$ -										
Jake Alley	\$ 54,488		54,488								
James A. Keller	\$ 81,420		70,587							10,833	
	\$ 506,895	\$ 76,039	\$ 139,578	\$ -	\$ 150,634	\$ 24,027	\$ 22,515	\$ -	\$ 43,269	\$ 10,833	\$ 40,000

Mulberry Manor, Inc.
Sch. V, Line 20, Col. 8
Analysis of Dues, Fees & Subscriptions
2007

Subscriptions	\$	458
Memberships		
Arc of IL		25
MES of IL		648
Chamber Dues		55
NFIB		100
Resident Account Bond		955
ADM License Renewal		200
Corp. Annual Report		100
Food Service Permit		95
Less		
Chamber Dues		(55)
NFIB		(100)
	\$	<u>2,481</u>

Mulberry Manor, Inc.
Reconciliation Sch. XI, Col. 6, Line 83 to
Sch. V, Line 30, Col. 8
2007

Sch. XI, Col. 6, Line 83	\$	29,296
kel-Tech Mgmt Allocation		<u>9,269</u>
Sch. V, Line 30, Col. 8	\$	<u>38,565</u>

Mulberry Manor, Inc.
Sch. V Line 36, Col. 4
2007

Bad Debt	\$	3,620
Insurance - Officers's Life		185
Tax Penalty		28
State Income Tax		<u>(93,365)</u>
Total	\$	<u>(89,532)</u>

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

Rental Property Costs Paid by Mulberry Manor

Interest Expense	\$	3,093
R/E Tax Expense		2,243
Rental Expenses		206
Depreciation Expense		<u>2,493</u>
Total	\$	<u>8,035</u>