

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 23360

	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	64	ICF/DD 16 or Less	64	23,360	6
7	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	21,923			21,923	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,923			21,923	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.85%

D. How many bed-hold days during this year were paid by the Department? 109 (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

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	109,955	4,159	5,933	120,047		120,047		120,047		1
2	Food Purchase		159,387		159,387		159,387		159,387		2
3	Housekeeping	56,503	16,171		72,674		72,674	360	73,034		3
4	Laundry		8,585	403	8,988		8,988		8,988		4
5	Heat and Other Utilities			75,672	75,672		75,672	431	76,103		5
6	Maintenance	50,028	20,323	5,910	76,261		76,261	20,093	96,354		6
7	Other (specify):*										7
8	TOTAL General Services	216,486	208,625	87,918	513,029		513,029	20,884	533,913		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	833,566	17,002	5,209	855,777		855,777	4,587	860,364		10
10a	Therapy		2,160	22,201	24,361		24,361		24,361		10a
11	Activities	24,965		758	25,723		25,723		25,723		11
12	Social Services		8,058	7,840	15,898		15,898	(4,715)	11,183		12
13	CNA Training	3,623		490	4,113		4,113		4,113		13
14	Program Transportation		8,262	6,028	14,290		14,290	1,661	15,951		14
15	Other (specify):* Day Training			763,967	763,967		763,967	(763,967)			15
16	TOTAL Health Care and Programs	862,154	35,482	813,693	1,711,329		1,711,329	(762,434)	948,895		16
	C. General Administration										
17	Administrative	149,328			149,328		149,328	21,707	171,035		17
18	Directors Fees			1,000	1,000		1,000		1,000		18
19	Professional Services			107,088	107,088		107,088	(101,731)	5,357		19
20	Dues, Fees, Subscriptions & Promotions			8,850	8,850		8,850	(4,530)	4,320		20
21	Clerical & General Office Expenses	31,973	8,302	13,257	53,532		53,532	34,234	87,766		21
22	Employee Benefits & Payroll Taxes			159,984	159,984		159,984	11,892	171,876		22
23	Inservice Training & Education			280	280		280	212	492		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			16,962	16,962		16,962	843	17,805		26
27	Other (specify):* Late Fees			2	2		2	(2)			27
28	TOTAL General Administration	181,301	8,302	307,423	497,026		497,026	(37,375)	459,651		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,259,941	252,409	1,209,034	2,721,384		2,721,384	(778,925)	1,942,459		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:

01/01/2010

Ending:

12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			18,312	18,312		18,312	9,361	27,673			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,912	4,912		4,912	(4,912)				32
33	Real Estate Taxes			33,951	33,951		33,951	609	34,560			33
34	Rent-Facility & Grounds			285,000	285,000		285,000	(282,799)	2,201			34
35	Rent-Equipment & Vehicles			740	740		740	395	1,135			35
36	Other (specify):* See Pg. 25			(976)	(976)		(976)	976				36
37	TOTAL Ownership			341,939	341,939		341,939	(276,370)	65,569			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			172,911	172,911		172,911		172,911			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			172,911	172,911		172,911		172,911			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,259,941	252,409	1,723,884	3,236,234		3,236,234	(1,055,295)	2,180,939			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$ (763,967)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,110)	22		4
5	Telephone, TV & Radio in Resident Rooms	(584)	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	9,967	30		9
10	Interest and Other Investment Income	(3,143)	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	(1,769)	32		14
15	Non-Care Related Owner's Transactions	(2,472)	30		15
16	Personal Expenses (Including Transportation)	(399)	20		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2)	27		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	(500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(212)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	1,375	36		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Pg. 5A	(4,929)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (772,080)		\$	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)	(283,215)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (283,215)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,055,295)		37

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

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

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

BHF USE ONLY

48		49		50		51		52	
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Mulberry Manor

ID# 0025411

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Flowers/Burial Expenses	\$ (1,092)	12	1
2	Tobacco	(1,097)	12	2
3	Gifts to Residents	(835)	12	3
4	Personal Items/Clothing	(1,691)	12	4
5	Personal Loan- Principal Adjusted to Actual	(214)	36	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,929)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
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	360	0	0	0	0	0	0	0	0	0	360	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(584)	1,015	0	0	0	0	0	0	0	0	0	431	5
6	Maintenance	0	279	19,814	0	0	0	0	0	0	0	0	20,093	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(584)	1,654	19,814	0	20,884	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	4,587	0	0	0	0	0	0	0	0	4,587	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	(4,715)	0	0	0	0	0	0	0	0	0	0	(4,715)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	1,661	0	0	0	0	0	0	0	0	0	1,661	14
15	Other (specify):*	(763,967)	0	0	0	0	0	0	0	0	0	0	(763,967)	15
16	TOTAL Health Care and Programs	(768,682)	1,661	4,587	0	(762,434)	16							
	C. General Administration													
17	Administrative	0	0	21,707	0	0	0	0	0	0	0	0	21,707	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(500)	769	(102,000)	0	0	0	0	0	0	0	0	(101,731)	19
20	Fees, Subscriptions & Promotions	(4,761)	231	0	0	0	0	0	0	0	0	0	(4,530)	20
21	Clerical & General Office Expenses	0	4,954	29,280	0	0	0	0	0	0	0	0	34,234	21
22	Employee Benefits & Payroll Taxes	(1,110)	13,002	0	0	0	0	0	0	0	0	0	11,892	22
23	Inservice Training & Education	0	212	0	0	0	0	0	0	0	0	0	212	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	843	0	0	0	0	0	0	0	0	0	843	26
27	Other (specify):*	(2)	0	0	0	0	0	0	0	0	0	0	(2)	27
28	TOTAL General Administration	(6,373)	20,011	(51,013)	0	(37,375)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(775,639)	23,326	(26,612)	0	(778,925)	29							

STATE OF ILLINOIS

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

01/01/2010 Ending:

Summary B

12/31/2010

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	7,495	1,866	0	0	0	0	0	0	0	0	0	9,361	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,912)	0	0	0	0	0	0	0	0	0	0	(4,912)	32
33	Real Estate Taxes	0	609	0	0	0	0	0	0	0	0	0	609	33
34	Rent-Facility & Grounds	0	2,201	(285,000)	0	0	0	0	0	0	0	0	(282,799)	34
35	Rent-Equipment & Vehicles	0	0	395	0	0	0	0	0	0	0	0	395	35
36	Other (specify):*	976	0	0	0	0	0	0	0	0	0	0	976	36
37	TOTAL Ownership	3,559	4,676	(284,605)	0	(276,370)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(772,080)	28,002	(311,217)	0	0	0	0	0	0	0	0	(1,055,295)	45

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JoAnn Keller	50	Pilot House	Cairo	kel-Tech Mgmt. Co.	Anna	Mgmt. Services
James K. Keller	50	Holly Hill	Anna	JR's Centre	Anna	Workshop
		Lincoln Square	Jonesboro	ILS 1-3 & 5-6	Anna	CILA
		Glen Brook	Vienna	ILS 4	Metropolis	CILA
		Krypton	Metropolis	ILS Land Trust	Anna	Land Trust
		New Way	Anna	J & J Partners	Anna	Land Trust

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%	\$ 360	\$	360	1
2	V	5 Heat and Other Utilities		kel-Tech Management Co.	25.00%	1,015		1,015	2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	279		279	3
4	V	14 Program Transportation		kel-Tech Management Co.	25.00%	1,661		1,661	4
5	V	19 Professional Services		kel-Tech Management Co.	25.00%	769		769	5
6	V	20 Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	231		231	6
7	V	21 Clerical & General		kel-Tech Management Co.	25.00%	4,954		4,954	7
8	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	13,002		13,002	8
9	V	23 Inservice Trn'g & Education		kel-Tech Management Co.	25.00%	212		212	9
10	V	26 Insurance		kel-Tech Management Co.	25.00%	843		843	10
11	V	30 Depreciation		kel-Tech Management Co.	25.00%	1,866		1,866	11
12	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	609		609	12
13	V	34 Rent-Facility		kel-Tech Management Co.	25.00%	2,201		2,201	13
14	Total		\$			\$ 28,002	\$ *	28,002	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	35 Rent- Equipment	\$	kel-Tech Management Co.	25.00%	\$ 395	\$	395	15
16	V	10 Nursing		kel-Tech Management Co.	25.00%	4,587		4,587	16
17	V	17 Administration		kel-Tech Management Co.	25.00%	21,707		21,707	17
18	V	21 Clerical		kel-Tech Management Co.	25.00%	29,280		29,280	18
19	V	6 Maintenance		kel-Tech Management Co.	25.00%	19,814		19,814	19
20	V								20
21	V								21
22	V	19 Professional Services	102,000	kel-Tech Management Co.	25.00%			(102,000)	22
23	V	34 Building Lease	285,000	J & J Partners	100.00%			(285,000)	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		\$ 387,000			\$ 75,783	\$ *	(311,217)	39

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

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JoAnn Keller	Owner/Admin.	Administrator	50.00	24,000	32	80.00	Admin. Wage	\$ 105,956	17-1	1
2	James K. Keller	Owner	Maintenance	50.00		10	25.00	Maint. Wage	14,400	6-1	2
3	Diana Alley	QSP		0.00	21,248	5	12.50	Program Wage	14,980	17-1	3
4	Natasha Davis	DSP		0.00	0	15	37.50	Program Wage	9,991	10-1	4
5											5
6											6
7	kel-Tech Allocation										7
8	Diana Alley							Nursing	4,587	19-3	8
9	Jacob Alley							Maintenance	19,814	19-3	9
10	James A. Keller							Administration	21,707	19-3	10
11											11
12											12
13								TOTAL	\$ 191,435		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: 01/01/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Mgmt Fee Contribution	333,596	8	\$ 1,100	\$ 102,000	\$ 336	1
2	3	Office Décor	Mgmt Fee Contribution	333,596	8	76	102,000	23	2
3	5	Utilities Elec/Gas	Mgmt Fee Contribution	333,596	8	2,942	102,000	900	3
4	5	Utilities Water	Mgmt Fee Contribution	333,596	8	377	102,000	115	4
5	6	Grounds Maintenance	Mgmt Fee Contribution	333,596	8	315	102,000	96	5
6	6	Maint. Supplies	Mgmt Fee Contribution	333,596	8	204	102,000	62	6
7	6	Maint. Vehicle	Mgmt Fee Contribution	333,596	8	393	102,000	120	7
8	14	Repairs Vehicles	Mgmt Fee Contribution	333,596	8	1,176	102,000	360	8
9	14	Transportation	Mgmt Fee Contribution	333,596	8	4,257	102,000	1,302	9
10	19	Legal & Accounting	Mgmt Fee Contribution	333,596	8	2,515	102,000	769	10
11	20	Dues Fees Subscriptions	Mgmt Fee Contribution	333,596	8	757	102,000	231	11
12	21	Bank Charges	Mgmt Fee Contribution	333,596	8	(45)	102,000	(14)	12
13	21	Contract Services	Mgmt Fee Contribution	333,596	8	1,740	102,000	532	13
14	21	Copier Expense Service Calls	Mgmt Fee Contribution	333,596	8	286	102,000	87	14
15	21	G & A Misc	Mgmt Fee Contribution	333,596	8	1,292	102,000	395	15
16	21	G & A Supplies	Mgmt Fee Contribution	333,596	8	6,821	102,000	2,086	16
17	21	Postage	Mgmt Fee Contribution	333,596	8	2,687	102,000	822	17
18	21	Telephone	Mgmt Fee Contribution	333,596	8	1,789	102,000	547	18
19	21	Cell Phone Expense	Mgmt Fee Contribution	333,596	8	1,223	102,000	374	19
20	21	Utilities - Internet	Mgmt Fee Contribution	333,596	8	408	102,000	125	20
21	22	Ins. Emp. Group	Mgmt Fee Contribution	333,596	8	20,343	102,000	6,220	21
22	22	Ins. W/C	Mgmt Fee Contribution	333,596	8	2,971	102,000	908	22
23	22	Payroll Tax Exp.	Mgmt Fee Contribution	333,596	8	19,211	102,000	5,874	23
24	23	Travel & Entertainment	Mgmt Fee Contribution	333,596	8	237	102,000	72	24
25	TOTALS					\$ 73,075	\$	\$ 22,342	25

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning: 01/01/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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	23	Adm. Staff Trn'g	Mgmt Fee Contribution	333,596	8	\$ 455	\$ 102,000	\$ 139	1
2	26	Ins. Bldg. & Liab.	Mgmt Fee Contribution	333,596	8	1,240	102,000	379	2
3	26	Ins. Vehicles	Mgmt Fee Contribution	333,596	8	1,516	102,000	464	3
4	30	Depreciation	Mgmt Fee Contribution	333,596	8	6,103	102,000	1,866	4
5	33	Real Estate Taxes	Mgmt Fee Contribution	333,596	8	1,990	102,000	608	5
6	34	Lease Bldg	Mgmt Fee Contribution	333,596	8	7,200	102,000	2,201	6
7	35	Lease Equip	Mgmt Fee Contribution	333,596	8	1,291	102,000	395	7
8	10	Nursing	Mgmt Fee Contribution	333,596	8	15,001	102,000	4,587	8
9	17	Administration	Mgmt Fee Contribution	333,596	8	70,992	102,000	21,706	9
10	21	Clerical	Mgmt Fee Contribution	333,596	8	95,761	102,000	29,280	10
11	6	Maintenance	Mgmt Fee Contribution	333,596	8	64,802	102,000	19,814	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 266,351	\$ 246,556	\$ 81,439	25

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

01/01/2010

Ending:

12/31/2010

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		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	Southern Trust Bank	X		Operating Line of Credit						3,143	6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$ 3,143	9							
B. Non-Facility Related*																		
10	Capaha Bank		X	Rental House Purchase	\$675.29	4/28/09	34,439		4/28/12	6.5000	1,769	10						
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related				\$675.29		\$ 34,439	\$		\$ 1,769	14							
15	TOTALS (line 9+line14)						\$ 34,439	\$		\$ 4,912	15							

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2009 report.		\$	34,650		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	33,860		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(790)		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	34,741		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	33,951		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
	2005	<u>28,689</u>	<u>8</u>	FOR BHF USE ONLY	
	2006	<u>30,674</u>	<u>9</u>		
	2007	<u>32,515</u>	<u>10</u>	13	FROM R. E. TAX STATEMENT FOR 2009 \$ 13
	2008	<u>31,625</u>	<u>11</u>	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2009	<u>33,860</u>	<u>12</u>	15	LESS REFUND FROM LINE 6 \$ 15
<u>Sch. IX, Line 7</u>	<u>33951</u>			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>kel-Tech Mgmt Alloc</u>	<u>609</u>				
<u>Sch VI, Line 14, Col. 1</u>	<u>-2472</u>				
<u>Sch. V. Line 33, Col. 8</u>	<u>32088</u>				

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mulberry Manor COUNTY Union

FACILITY IDPH LICENSE NUMBER 0025411

CONTACT PERSON REGARDING THIS REPORT Ashley Alley

TELEPHONE (618) 833-5070 x11 FAX #: (618) 833-4993

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <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>1,748.96</u>	\$ <u>1,748.96</u>
2.	<u>05-20-03-682</u>	<u>S PT W 1/2 SE S of RD</u>	\$ <u>27,602.92</u>	\$ <u>27,602.92</u>
3.	<u>05-20-03-683</u>	<u>S PT W 1/2 SE S of RD</u>	\$ <u>2,032.06</u>	\$ <u>2,032.06</u>
4.	<u>05-20-03-679</u>	<u>S20 T12 R1W W PT S PT W 1/2 SE S</u>	\$ <u>2,476.50</u>	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
TOTALS			\$ <u><u>33,860.44</u></u>	\$ <u><u>31,383.94</u></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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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:

01/01/2010 Ending:

12/31/2010

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Healthcare</u>	<u>76,230</u>	<u>1967</u>	<u>\$ 8,687</u>	<u>1</u>
2	<u>Healthcare</u>	<u>45,000</u>	<u>1976</u>	<u>2,700</u>	<u>2</u>
3	TOTALS	121,230		\$ 11,387	3

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

01/01/2010 Ending:

12/31/2010

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	30		1972		\$ 172,058	\$	30	\$	\$	\$	4
5	28		1975		151,678		27				5
6	6		1979		4,663		23				6
7			1979		40,400		15				7
8			1987		16,300		30	543	543	381,223	8
	Improvement Type**										
9	Gazebo		1986		2,561		5			2,561	9
10	Laundry Room		1990		18,146	576	31.5	454	(122)	9,267	10
11	Landscaping		1990		505		15			505	11
12	Central A/C		1990		9,323		10	272	272	9,050	12
13	Improvements - blue House		1991		4,817	153	31.5	120	(33)	2,301	13
14	Blacktop Driveway		1992		3,260		15	163	163	3,016	14
15	New Roof		1992		8,055		15	403	403	7,454	15
16	Remodeled Living Room		1992		1,203		15	60	60	1,110	16
17	Remodeling		1985		1,867		15			1,867	17
18	Remodeling - Rest Room		1988		10,790		15			10,790	18
19	Seamless Gutters		1993		1,536		15	77	77	1,347	19
20	A/C & Heaters		1993		8,823		15	441	441	7,718	20
21	Dining Room Improvements		1995		9,127	525	15	456	(69)	6,840	21
22	Bath, Carpet & Fencing		1995		4,428	295	15	295		4,277	22
23	Carpet		1997		1,684		7			1,684	23
24	Smoking Room Addition		1997		46,392	1189	39	1,160	(29)	15,177	24
25	Smoking Room Equipment		1998		952		7			952	25
26	A/C - C Wing		1998		2,446	163	15	163		2,037	26
27	Kitchen Cabnets		1998		779		7			779	27
28	A/C Office		1998		1,059	71	15	71		887	28
29	Storage Building		1999		3,857	257	15	257		2,955	29
30	Water Garden		2001		2,922	195	15	195		1,771	30
31	A/C Compressor		2001		1,027	69	15	68	(1)	658	31
32	Fire Supression System		2003		1,716	80	15	114	34	903	32
33	Jo ann's Office Remodel		2003		8,543	399	15	570	171	4,417	33
34	A/C Laundry Room		2003		1,068	36	15	71	35	533	34
35	Furnace - Blue House		2004		2,213	65	15	148	83	1,023	35
36	Stopper II Fire Alarm		2004		637		7	91	91	614	36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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 Fence	2004	\$ 5,350	\$ 158	15	\$ 357	\$ 199	\$ 2,261	37
38	A/C Unit Roof Mount	2004	2,473	73	15	165	92	1,100	38
39	Vinyl Windows	2005	411	27	15	27		160	39
40	Carpet Office	2006	954		7	136	136	646	40
41	Flooring - Blue House	2006	1,397	93	15	93		388	41
42	Lumber - Blue House	2006	1,742	116	15	116		474	42
43	Drainage System	2006	8,909	594	15	594		2,425	43
44	Base Board - Carpet	2006	96		7	14	14	57	44
45	Door Alarm / Bumber Guard	2007	1,315	88	15	88		308	45
46	Windows	2008	783	26	15	52	26	137	46
47	Roof - Laundry Room	2008	1,239	41	15	83	42	218	47
48	New Wall	2009	598	28	15	40	12	50	48
49	Fire Doors	2010	1,491	783	15	66	(717)	66	49
50	Door Knobs & Keys	2010	835	439	15	37	(402)	37	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)		\$ 572,428	\$ 6,539		\$ 8,060	\$ 1,521	\$ 492,043	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:

01/01/2010

Ending:

12/31/2010

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	\$ 79,879	\$ 342	\$ 10,031	\$ 9,689		\$ 50,871	71
72	Current Year Purchases	6,970	6,970	340	(6,630)		7,310	72
73	Fully Depreciated Assets	64,307					64,307	73
74								74
75	TOTALS	\$ 151,156	\$ 7,312	\$ 10,371	\$ 3,059		\$ 122,488	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	\$	\$	\$		\$ 25,942	76
77	Healthcare	1997 Ford Van	1997	25,653					25,653	77
78	Healthcare	1998 Ford Van	1999	29,272					29,272	78
79	Healthcare	See Pg. 25		36,881	1,989	7,376	5,387		27,049	79
80	TOTALS			\$ 117,748	\$ 1,989	\$ 7,376	\$ 5,387		\$ 107,916	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)	\$ 852,719	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,840	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,807	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,967	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 722,447	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	\$ 14,937	86
87	Rental Prop. - Furniture & Fixtures	1,141	51	1,059	87
88	Rental Property - Improvements	5,961	275	3,116	88
89	Rental Property - Land	5,000			89
90					90
91	TOTALS	\$ 71,115	\$ 2,472	\$ 19,112	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

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: \$ _____ Description: _____

(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

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. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA <u>44</u></p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA <u>86</u></p>
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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)	271	305		576
4	Clinical Wages (b)	529	595		1,124
5	In-House Trainer Wages (c)	905	1,018		1,923
6	Transportation				
7	Contractual Payments	245	245		490
8	CNA Competency Tests				
9	TOTALS	\$ 1,950	\$ 2,163	\$	\$ 4,113
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,113			

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

- (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	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

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

Facility Name & ID Number **Mulberry Manor**

0025411

Report Period Beginning: **01/01/2010**

Ending: **12/31/2010**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2010** (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	\$ 1,075,989	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(53)		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)	1,708,490		8
9	Other(specify): <u>See Pg. 25</u>	1,517		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,785,943	\$	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	180,634		15
16	Equipment, at Historical Cost	270,046		16
17	Accumulated Depreciation (book methods)	(378,362)		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)	\$ 136,331	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,922,274	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 20,638	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,286		30
31	Accrued Taxes Payable (excluding real estate taxes)	(29,306)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,741		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Employee Benfits Payable</u>	2,002		36
37	<u>Client Memorial Fund</u>	475		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 48,836	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			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)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 48,836	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,873,438	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,922,274	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,817,990	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,817,990	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	55,448	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)	\$ 55,448	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)	\$ 2,873,438	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 01/01/2010Ending: 12/31/2010**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	\$ 2,476,739	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,476,739	3
B. Ancillary Revenue			
4	Day Care	763,967	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 763,967	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	1,755	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)	\$ 1,755	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	43,622	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 43,622	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Rental Revenue</u>	5,600	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,600	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,291,683	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	513,029	31
32	Health Care	1,711,329	32
33	General Administration	497,026	33
B. Capital Expense			
34	Ownership	341,939	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	172,911	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,236,234	40
41	Income before Income Taxes (line 30 minus line 40)**	55,449	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 55,449	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: **01/01/2010**

Ending:

12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,937	2,081	\$ 46,427	\$ 22.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,083	2,147	32,583	15.18	3
4	Licensed Practical Nurses	5,478	5,654	82,651	14.62	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,990	2,102	24,965	11.88	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	9,594	10,023	109,955	10.97	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,193	2,289	50,028	21.86	17
18	Housekeepers	5,991	6,163	56,503	9.17	18
19	Laundry					19
20	Administrator	3,585	3,745	149,323	39.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,132	2,204	31,973	14.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	4,631	4,831	82,034	16.98	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	58,887	60,482	593,499	9.81	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,501	101,721	\$ 1,259,941 *	\$ 12.39	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	131	\$ 5,932	1-3	35
36	Medical Director	96	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	6	240	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	110	3,750	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	196	7,840	12-3	45
46	Other(specify) <u>Dental Consultant</u>	As Needed	900	10a-3	46
47	<u>Psychologist Consultant</u>	53	3,975	10a-3	47
48	<u>See Pg. 25</u>		10,919	10a-3	48
49	TOTAL (lines 35 - 48)	592	\$ 40,756		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

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 01/01/2010 Ending: 12/31/2010**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. \$ 3,346 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. \$ 172,911
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. \$ 1,110 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: _____
- (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 2010 - Dec. 31 2010

	Totals / Entity	Mulberry Manor	Pilot House	Lincoln Square	kel-Tech Mgmt	Krypton	Glen Brook
Diana Alley	\$ 51,225	14,976	-	21,024	15,001	224	-
Jo Ann Keller	\$ 129,923	105,923	24,000	-		-	-
James K. Keller	\$ 14,400	14,400	-	-		-	-
Jacob Alley	\$ 57,420	-	-	224	56,972	224	-
Ashley Alley	\$ 33,639				33,639		
Josh Alley	\$ 10,017	-	-	4,622		5,395	-
James A. Keller	\$ 89,216	-	-	-	70,992	-	18,224
	\$ 385,840	\$ 135,299	\$ 24,000	\$ 25,870	\$ 176,604	\$ 5,843	\$ 18,224

Mulberry Manor, Inc.
Sch. V, Line 20, Col. 8
Analysis of Dues, Fees & Subscriptions
2010

Subscriptions	\$	476
Memberships		
MES of IL		847
Sams Club Membership		70
Other Memberships		399
License Fees		235
PO Box Annual Fee		180
Resident Account Surety Bond		1,220
Corp. Annual Report		100

Less

Other Memberships		<u>(399)</u>
	\$	<u>3,128</u>

Mulberry Manor, Inc.
Reconciliation Sch. XI, Col. 6, Line 83 to
Sch. V, Line 30, Col. 8
2010

Sch. XI, Col. 6, Line 83	\$	25,807
kel-Tech Mgmt Allocation		1,866

Sch. V, Line 30, Col. 8	\$	<u>27,673</u>
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Mulberry Manor, Inc.
Sch. V Line 36, Col. 3
2010

Insurance - Officers's Life		185
Personal Loan-Adjustment to Actual		214
Federal Income Tax		<u>(1,375)</u>

Total	\$	<u>(976)</u>
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Mulberry Manor, Inc.
 Sch. XX, Question 14; Schedule of Costs
 2010

Rental Property Costs Paid by Mulberry Manor

Interest Expense	\$ 1,707
R/E Tax Expense	2,477
Depreciation Expense	<u>2,472</u>
Total	<u>\$ 6,656</u>

Mulberry Manor, Inc.
 Details for Sch. XI, Line 79
 2010

Use	Model, Make and Year	Year Acquired	Cost	Current Book Deprec	S/L Deprec.	Adjust.	Life In Yrs	Acc. Deprec.
Healthcare		2007	35001	1775	7000	2100	5	26250
2007 Buick Terraza								
Healthcare		2008	1880	214	376	-940	5	799
1999 Ford Transmission			36881	1989	7376	1160		27049

Mulberry Manor, Inc.
 Sch. XV Line 9
 2010

A/R Employee Advances	\$ 923
A/R Client Ck Cashing	594
Total	<u>\$ 1,517</u>

Mulberry Manor, Inc.
 Sch. XVIII Sec. B Line 48
 2010

	# Hours	Total Cost	Sch. V Ref.
Psychiatric Consultant	80	6000	10a-3
Behavior Therapist	65	4919	10a-3
Total		<u>\$ 10,919</u>	