

Facility Name & ID Number Mulberry Manor

0025411 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	64	Intermediate/DD	64	23,360	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,360	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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	16,848			16,848	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,848			16,848	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.12%

D. How many bed-hold days during this year were paid by the Department? 134 (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: 12/31/2015 Fiscal Year: 12/31/2015

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

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	75,227	4,129		79,356		79,356	79,356		1	
2	Food Purchase		138,002		138,002		138,002	138,002		2	
3	Housekeeping	27,616	12,158		39,774		39,774	321	40,095	3	
4	Laundry		4,758		4,758		4,758	4,758		4	
5	Heat and Other Utilities			60,383	60,383		60,383	904	61,287	5	
6	Maintenance	37,137	12,692	12,351	62,180		62,180	17,629	79,809	6	
7	Other (specify):*									7	
8	TOTAL General Services	139,980	171,739	72,734	384,453		384,453	18,854	403,307	8	
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200	7,200		9	
10	Nursing and Medical Records	836,190	21,228	12,611	870,029		870,029	4,269	874,298	10	
10a	Therapy		4,163	14,668	18,831		18,831	18,831		10a	
11	Activities	24,758		1,102	25,860		25,860	25,860		11	
12	Social Services		4,050	3,250	7,300		7,300	(1,787)	5,513	12	
13	CNA Training	3,140		980	4,120		4,120	4,120		13	
14	Program Transportation		8,525	3,656	12,181		12,181	1,223	13,404	14	
15	Other (specify):* DT Program			464,230	464,230		464,230	(464,230)		15	
16	TOTAL Health Care and Programs	864,088	37,966	507,697	1,409,751		1,409,751	(460,525)	949,226	16	
	C. General Administration										
17	Administrative	114,455			114,455		114,455	20,019	134,474	17	
18	Directors Fees									18	
19	Professional Services			102,627	102,627		102,627	(92,706)	9,921	19	
20	Dues, Fees, Subscriptions & Promotions			13,037	13,037		13,037	(1,462)	11,575	20	
21	Clerical & General Office Expenses	30,472	8,561	9,875	48,908		48,908	39,137	88,045	21	
22	Employee Benefits & Payroll Taxes			144,113	144,113		144,113	8,784	152,897	22	
23	Inservice Training & Education			488	488		488	488		23	
24	Travel and Seminar			1,044	1,044		1,044	1,044		24	
25	Other Admin. Staff Transportation									25	
26	Insurance-Prop.Liab.Malpractice			8,016	8,016		8,016	516	8,532	26	
27	Other (specify):* Late Fee/Fin. Charge			191	191		191	15	206	27	
28	TOTAL General Administration	144,927	8,561	279,391	432,879		432,879	(25,697)	407,182	28	
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,148,995	218,266	859,822	2,227,083		2,227,083	(467,368)	1,759,715	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:

1/1/2015

Ending:

12/31/2015

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			12,632	12,632		12,632	22,350	34,982			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			678	678		678	(1,066)	(388)			32
33	Real Estate Taxes			35,656	35,656		35,656	(1,782)	33,874			33
34	Rent-Facility & Grounds			228,000	228,000		228,000	(225,985)	2,015			34
35	Rent-Equipment & Vehicles			1,704	1,704		1,704	501	2,205			35
36	Other (specify):* See Pg. 24			806	806		806	(805)	1			36
37	TOTAL Ownership			279,476	279,476		279,476	(206,787)	72,689			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			111,200	111,200		111,200		111,200			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			111,200	111,200		111,200		111,200			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,148,995	218,266	1,250,498	2,617,759		2,617,759	(674,155)	1,943,604			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: 1/1/2015

Ending: 12/31/2015

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	\$ (464,230)	15	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(600)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,856	30		9
10	Interest and Other Investment Income	(678)	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	(678)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(429)	36		18
19	Entertainment				19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance	(246)	36		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(130)	36		24
25	Fund Raising, Advertising and Promotional	(1,002)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See pf. 5A	(5,697)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (455,934)		\$	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)	(218,221)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (218,221)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (674,155)		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

Mulberry Manor

ID# 0025411

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Floral	\$ (158)	12	1
2	Gifts to Clients	(1,092)	12	2
3	Clothing	(314)	12	3
4	Tobacco	(223)	12	4
5	Rental Property Real Estate Taxes	(2,410)	33	5
6	IDPH "B" Violation	(1,500)	20	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		(5,697)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	321	0	0	0	0	0	0	0	0	0	321	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	904	0	0	0	0	0	0	0	0	0	904	5
6	Maintenance	0	344	17,285	0	0	0	0	0	0	0	0	17,629	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	1,569	17,285	0	18,854	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	4,269	0	0	0	0	0	0	0	0	4,269	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	(1,787)	0	0	0	0	0	0	0	0	0	0	(1,787)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	1,223	0	0	0	0	0	0	0	0	0	1,223	14
15	Other (specify):*	(464,230)	0	0	0	0	0	0	0	0	0	0	(464,230)	15
16	TOTAL Health Care and Programs	(466,017)	1,223	4,269	0	(460,525)	16							
	C. General Administration													
17	Administrative	0	0	20,019	0	0	0	0	0	0	0	0	20,019	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,568	(98,274)	0	0	0	0	0	0	0	0	(92,706)	19
20	Fees, Subscriptions & Promotions	(2,602)	1,140	0	0	0	0	0	0	0	0	0	(1,462)	20
21	Clerical & General Office Expenses	0	4,667	34,470	0	0	0	0	0	0	0	0	39,137	21
22	Employee Benefits & Payroll Taxes	(600)	9,384	0	0	0	0	0	0	0	0	0	8,784	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	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	516	0	0	0	0	0	0	0	0	0	516	26
27	Other (specify):*	0	15	0	0	0	0	0	0	0	0	0	15	27
28	TOTAL General Administration	(3,202)	21,290	(43,785)	0	(25,697)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(469,219)	24,082	(22,231)	0	(467,368)	29							

STATE OF ILLINOIS

Facility Name & ID Number Mulberry Manor# 0025411

Report Period Beginning:

1/1/2015 Ending:

Summary B

12/31/2015

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	17,856	4,494	0	0	0	0	0	0	0	0	0	22,350	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,356)	290	0	0	0	0	0	0	0	0	0	(1,066)	32
33	Real Estate Taxes	(2,410)	628	0	0	0	0	0	0	0	0	0	(1,782)	33
34	Rent-Facility & Grounds	0	0	(225,985)	0	0	0	0	0	0	0	0	(225,985)	34
35	Rent-Equipment & Vehicles	0	0	501	0	0	0	0	0	0	0	0	501	35
36	Other (specify):*	(805)	0	0	0	0	0	0	0	0	0	0	(805)	36
37	TOTAL Ownership	13,285	5,412	(225,484)	0	(206,787)	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)	(455,934)	29,494	(247,715)	0	0	0	0	0	0	0	0	(674,155)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JoAnn Keller	50	Glen Brook of Vienna	Vienna	kel-Tech Mgmt. Co.	Anna	Mgmt. Company
James K. Keller Family Trust	50			JR's Centre	Anna	Workshop
				Independent Living Ser	Anna & Metropolis	CILA
				Krypton	Metropolis	CILA
				Lincoln Square	Jonesboro & Dongola	CILA
				Pilot House of Cairo	Cairo	CILA
				CIL	Anna	CILA

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	3 Houskeeping	\$	kel-Tech Management Co.	25.00%	\$ 321	\$	321	1
2	V	5 Heat & Other Utilities		kel-Tech Management Co.	25.00%	904		904	2
3	V	6 Maintenance		kel-Tech Management Co.	25.00%	344		344	3
4	V	14 Program Transportation		kel-Tech Management Co.	25.00%	1,223		1,223	4
5	V	19 Professional Services		kel-Tech Management Co.	25.00%	5,568		5,568	5
6	V	20 Dues, Fees, & Subscriptions		kel-Tech Management Co.	25.00%	1,140		1,140	6
7	V	21 Clerical & General		kel-Tech Management Co.	25.00%	4,667		4,667	7
8	V	22 Employee Benefits		kel-Tech Management Co.	25.00%	9,384		9,384	8
9	V	26 Insurance		kel-Tech Management Co.	25.00%	516		516	9
10	V	27 Late Fee/Finance Charge		kel-Tech Management Co.	25.00%	15		15	10
11	V	30 Depreciation		kel-Tech Management Co.	25.00%	4,494		4,494	11
12	V	32 Interest Notes		kel-Tech Management Co.	25.00%	290		290	12
13	V	33 Real Estate Taxes		kel-Tech Management Co.	25.00%	628		628	13
14	Total		\$			\$ 29,494	\$ *	29,494	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 Rent- Facility	\$	kel-Tech Management Co.	25.00%	\$ 2,015	\$ 2,015
16	V	35 Rent - Equipment		kel-Tech Management Co.	25.00%	501	501
17	V				25.00%		
18	V	10 Nursing		kel-Tech Management Co.	25.00%	4,269	4,269
19	V	17 Administration		kel-Tech Management Co.	25.00%	20,019	20,019
20	V	21 Clerical		kel-Tech Management Co.	25.00%	34,470	34,470
21	V	6 Maintenance		kel-Tech Management Co.	25.00%	17,285	17,285
22	V						
23	V						
24	V	19 Professional Services	98,274	kel-Tech Management Co.	25.00%		(98,274)
25	V	34 Building Lease	114,000	JoAnn Keller	50.00%		(114,000)
26	V	34 Building Lease	114,000	James K. Keller Family Trust	50.00%		(114,000)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 326,274			\$ 78,559	\$ * (247,715)

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

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	James A. Keller	50	Glen Brook of Vienna	Vienna				1
2	Norine Keller	50	Glen Brook of Vienna	Vienna				2
3	Don Pippins	50			CIL	Anna	CILA's	3
4	Denise Pippins	50			CIL	Anna	CILA's	4
5	Don Pippins	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	5
6	Jacob L. Alley	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	6
7	James A. Keller	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	7
8	James K. Keller Family Trust	25			kel-Tech Mgmt. Co.	Anna	Mgmt. Services	8
9	Jacob L. Alley	33			ILS	Anna & Metropolis	CILA's	9
10	James A. Keller	33			ILS	Anna & Metropolis	CILA's	10
11	James K. Keller Family Trust	33			ILS	Anna & Metropolis	CILA's	11
12	JoAnn Keller	33			ILS	Anna & Metropolis	CILA's	12
13	JoAnn Keller	33			ILS Land Trust	Anna	Land Trust	13
14	Jacob L. Alley	33			ILS Land Trust	Anna	Land Trust	14
15	James A. Keller	33			ILS Land Trust	Anna	CILA's	15
16	James K. Keller Family Trust	33			ILS Land Trust	Anna	CILA's	16
17	Josh Alley	20			Krypton	Metropolis	CILA's	17
18	Jacob L. Alley	30			Krypton	Metropolis	CILA's	18
19	Diana Alley	30			Krypton	Metropolis	CILA's	19
20	Jacob L. Alley, II	20			Krypton	Metropolis	CILA's	20
21	Josh Alley	20			Lincoln Square	Jonesboro & Dongola	CILA's	21
22	Jacob L. Alley	30			Lincoln Square	Jonesboro & Dongola	CILA's	22
23	Diana Alley	30			Lincoln Square	Jonesboro & Dongola	CILA's	23
24	Jacob L. Alley, II	20			Lincoln Square	Jonesboro & Dongola	CILA's	24
25	JoAnn Keller	50			Pilot House of Cairo	Cairo	CILA's	25
26	James K. Keller Family Trust	50			Pilot House of Cairo	Cairo	CILA's	26
27	Denise Pippins	16			JR's Centre	Anna	Workshop	27
28	Don Pippins	16			JR's Centre	Anna	Workshop	28
29	JoAnn Keller	16			JR's Centre	Anna	Workshop	29
30								30

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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		32	80.00	Admin.	\$ 102,462	17-1	1
2	Ashley Alley	QIDP	QIDP	0.00		5	10.00		15,202	10-1	2
3											3
4											4
5											5
6	kel-Tech Allocation										6
7	Diana Alley							Nursing	4,269		7
8	Jacob Alley							Maintenance	17,285		8
9	James A. Keller							Administration	20,019		9
10	Ashley Alley							Clerical	12,754		10
11											11
12											12
13								TOTAL	\$ 171,991		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:

1/1/2015

Ending: 2/31/2015

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 St
 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	Houskeeping Supplies	Mgmt Fee Contribution	351,160	9	\$ 35	\$	98,274	\$ 10	1
2	3	Houskeeping	Mgmt Fee Contribution	351,160	9	1,096		98,274	307	2
3	3	Home/Office Décor	Mgmt Fee Contribution	351,160	9	17		98,274	5	3
4	5	Utilities Gas	Mgmt Fee Contribution	351,160	9	2,826		98,274	791	4
5	5	Utilities Water	Mgmt Fee Contribution	351,160	9	404		98,274	113	5
6	6	Maint. Building	Mgmt Fee Contribution	351,160	9	316		98,274	88	6
7	6	Maint. Supplies	Mgmt Fee Contribution	351,160	9	210		98,274	59	7
8	6	Grounds Maint.	Mgmt Fee Contribution	351,160	9	473		98,274	132	8
9	6	Preventative Maint.	Mgmt Fee Contribution	351,160	9	182		98,274	51	9
10	6	Repairs Grounds	Mgmt Fee Contribution	351,160	9	50		98,274	14	10
11	14	Repairs Vehicle	Mgmt Fee Contribution	351,160	9	114		98,274	32	11
12	14	Transportation	Mgmt Fee Contribution	351,160	9	3,233		98,274	905	12
13	14	Insurance Vehicles	Mgmt Fee Contribution	351,160	9	774		98,274	217	13
14	14	Maint. Vehicle	Mgmt Fee Contribution	351,160	9	250		98,274	70	14
15	19	ADP Payroll Services	Mgmt Fee Contribution	351,160	9	19,020		98,274	5,323	15
16	19	Legal & Accounting	Mgmt Fee Contribution	351,160	9	875		98,274	245	16
17	20	Contributions	Mgmt Fee Contribution	351,160	9	150		98,274	42	17
18	20	Dues Fees Subscriptions	Mgmt Fee Contribution	351,160	9	3,922		98,274	1,098	18
19	21	G & A Supplies	Mgmt Fee Contribution	351,160	9	6,012		98,274	1,682	19
20	21	Postage	Mgmt Fee Contribution	351,160	9	2,006		98,274	561	20
21	21	Bank Charges	Mgmt Fee Contribution	351,160	9	5		98,274	1	21
22	21	Copier Expense Service Calls	Mgmt Fee Contribution	351,160	9	23		98,274	6	22
23	21	G&A Misc.	Mgmt Fee Contribution	351,160	9	488		98,274	137	23
24										24
25	TOTALS					\$ 42,481	\$		\$ 11,889	25

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization kel-Tech Management Co.
 Street Address 158 E. Vienna St
 City / State / Zip Code Anna IL 62906
 Phone Number (618) 833-5070 x11
 Fax Number (618) 833-4993

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	21	Software Expense	Mgmt Fee Contribution	351,160	9	\$ 2,783	\$ 98,274	\$ 779	1	
2	21	Telephone	Mgmt Fee Contribution	351,160	9	1,497	98,274	419	2	
3	21	Cell Phone Expense	Mgmt Fee Contribution	351,160	9	1,243	98,274	348	3	
4	21	Utilities - Internet	Mgmt Fee Contribution	351,160	9	1,037	98,274	290	4	
5	21	IT Services	Mgmt Fee Contribution	351,160	9	1,581	98,274	442	5	
6	22	Ins. Emp. Group	Mgmt Fee Contribution	351,160	9	10,022	98,274	2,805	6	
7	22	Ins. W/C	Mgmt Fee Contribution	351,160	9	2,849	98,274	797	7	
8	22	Payroll Tax Expense	Mgmt Fee Contribution	351,160	9	20,579	98,274	5,759	8	
9	22	Misc. Emp Benefits	Mgmt Fee Contribution	351,160	9	81	98,274	23	9	
10	26	Insurance Bldg & Liab	Mgmt Fee Contribution	351,160	9	1,843	98,274	516	10	
11	27	Late Fee/Finance Charge	Mgmt Fee Contribution	351,160	9	54	98,274	15	11	
12	30	Depreciation	Mgmt Fee Contribution	351,160	9	16,058	98,274	4,494	12	
13	32	Interest Notes	Mgmt Fee Contribution	351,160	9	1,035	98,274	290	13	
14	33	Real Estate Taxes	Mgmt Fee Contribution	351,160	9	2,244	98,274	628	14	
15	34	Lease Bldg	Mgmt Fee Contribution	351,160	9	7,200	98,274	2,015	15	
16	35	Lease Equip	Mgmt Fee Contribution	351,160	9	1,789	98,274	501	16	
17	10	Nursing	Mgmt Fee Contribution	351,160	9	15,251	15,251	98,274	4,268	17
18	17	Administration	Mgmt Fee Contribution	351,160	9	71,523	71,523	98,274	20,016	18
19	21	Clerical	Mgmt Fee Contribution	351,160	9	123,149	123,149	98,274	34,464	19
20	6	Maintenance	Mgmt Fee Contribution	351,160	9	61,755	61,755	98,274	17,282	20
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 343,573	\$ 271,678	\$ 96,151	25	

Facility Name & ID Number

Mulberry Manor

0025411

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	AJ National Bank		X	2010 E-350 Van Loan	\$357.49	4/30/13	\$ 18,489	\$ 9,303	4/30/15	6.0000	\$ 678	1						
2												2						
3												3						
4												4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$357.49		\$ 18,489	\$ 9,303			\$ 678	9						
	B. Non-Facility Related*																	
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 18,489	\$ 9,303			\$ 678	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 2014 report.		\$	<u>32,817</u>	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.)		\$	<u>35,692</u>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>2,875</u>	3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>32,781</u>	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.		\$	<u>35,656</u>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2010	<u>32,100</u>	8	FOR BHF USE ONLY	
	2011	<u>30,329</u>	9	13	FROM R. E. TAX STATEMENT FOR 2014 \$ 13
	2012	<u>33,814</u>	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2013	<u>32,394</u>	11	15	LESS REFUND FROM LINE 6 \$ 15
	2014	<u>35,692</u>	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
<u>Sch. IX, Line 7</u>	<u>32,781</u>				
<u>kel-Tech Mgmt. Alloc.</u>	<u>628</u>				
<u>Less: Rental Property</u>	<u>-2,410</u>				
<u>Sch V. Line 33, Col. 8</u>	<u>33,874</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.

2014 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 2014 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 2014.

(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>900.52</u>	\$ <u>900.52</u>
2. <u>05-20-03-683</u>	<u>S PT W 1/2 SE S OF RD</u>	\$ <u>1,308.46</u>	\$ <u>1,308.46</u>
3. <u>05-20-03-682</u>	<u>S PT W 1/2 SE S OF RD</u>	\$ <u>31,072.72</u>	\$ <u>31,072.72</u>
4. <u>05-20-03-679</u>	<u>S20 T12 R1W W PT S PT W 1/2 SE S</u>	\$ <u>2,409.86</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>35,691.56</u></u>	\$ <u><u>33,281.70</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:

1/1/2015 Ending:

12/31/2015

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).

1. Apartment

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	Healthcare	76,230	1967	\$ 8,687	1
2	Healthcare	45,000	1976	2,700	2
3	TOTALS	121,230		\$ 11,387	3

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$	\$	\$ 172,058	4
5	28		1975		151,678		27			151,678	5
6	6		1979		4,663		23			4,633	6
7			1979		40,400		15			40,400	7
8			1987		16,300		30	543	543	15,477	8
	Improvement Type**										
9	Gazebo		1986		2,561		5			2,561	9
10	Laundry Room		1990		18,146	576	31.5	454	(122)	11,537	10
11	Landscaping		1990		505		15			505	11
12	Central A/C		1990		9,323		10			9,050	12
13	Improvements - Blue House		1991		4,817	153	31.5	120	(33)	2,901	13
14	Blacktop Driveway		1992		3,260		15			3,260	14
15	New Roof		1992		8,055		15			8,055	15
16	Remodeled Living Room		1992		1,203		15			1,203	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			1,536	19
20	A/C & Heaters		1993		8,823		15			8,823	20
21	Dining Room Improvements		1995		9,127		15	463	463	9,127	21
22	Bath, Carpet & Fencing		1995		4,428		15			4,428	22
23	Carpet		1997		1,684		7			1,684	23
24	Smoking Room Addition		1997		46,392	1,189	39	1,160	(29)	20,977	24
25	Smoking Room Equipment		1998		952		7			952	25
26	A/C - C Wing		1998		2,446		15			2,446	26
27	Kitchen Cabnets		1998		779		7			779	27
28	A/C Office		1998		1,059		15			1,059	28
29	Storage Building		1999		3,857		15			3,857	29
30	Water Garden		2001		2,922	195	15	195		2,746	30
31	A/C Compressor		2001		1,027	69	15	68	(1)	998	31
32	Fire Supression System		2003		1,716	80	15	114	34	1,473	32
33	Jo ann's Office Remodel		2003		8,543	399	15	570	171	7,267	33
34	A/C Laundry Room		2003		1,068	36	15	71	35	888	34
35	Furnace - Blue House		2004		2,213	65	15	148	83	1,763	35
36	Stopper II Fire Alarm		2004		637		7			637	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:

1/1/2015

Ending:

12/31/2015

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	\$ 4,046	37
38	A/C Unit Roof Mount	2004	2,473	73	15	165	92	1,925	38
39	Vinyl Windows	2005	411	27	15	27		295	39
40	Carpet Office	2006	954		7			954	40
41	Flooring - Blue House	2006	1,397	93	15	93		853	41
42	Lumber - Blue House	2006	1,742	116	15	116		1,054	42
43	Drainage System	2006	8,909	594	15	594		5,395	43
44	Base Board - Carpet	2006	96		7			96	44
45	Door Alarm / Bumber Guard	2007	1,315	88	15	88		748	45
46	Windows	2008	783	26	15	52	26	397	46
47	Roof - Laundry Room	2008	1,239	41	15	83	42	633	47
48	New Wall	2009	598	18	15	40	22	250	48
49	Fire Doors	2010	1,491	46	15	99	53	561	49
50	Door Knobs & Keys	2010	835	26	15	56	30	317	50
51	Sprinkler System	2011	9,462	950	7	1,352	402	5,408	51
52	Shower	2011	998	70	15	67	(3)	296	52
53	Gravel	2011	185	13	15	12	(1)	48	53
54	Sprinkler System	2012	60,000		7	8,571	8,571	33,570	54
55	Water System Upgrade	2012	10,460	403	15	697	294	2,730	55
56	Sprinkler System	2012	1,206		7	172	172	645	56
57	Compressor Unit	2012	2,090		5	299	299	1,021	57
58	Door Alarm	2012	1,374		5	275	275	917	58
59	Security System	2012	2,115		5	423	423	1,340	59
60	Sprinkler System	2013	7,000		7	1,000	1,000	2,500	60
61	Metal Carport	2015	82	43	5	2	(41)	2	61
62	Metal Carport	2015	795	418	5	20	(398)	20	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 668,195	\$ 5,965		\$ 18,566	\$ 12,601	\$ 573,436	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 43,316	\$ 1,410	\$ 6,681	\$ 5,271		\$ 28,180	71
72	Current Year Purchases	1,903	1,137	184	(953)		184	72
73	Fully Depreciated Assets	135,463					135,463	73
74								74
75	TOTALS	\$ 180,682	\$ 2,547	\$ 6,865	\$ 4,318		\$ 163,827	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	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	See Pg 24		61,604	4,120	5,057	937	5	49,355	79
80	TOTALS			\$ 142,471	\$ 4,120	\$ 5,057	\$ 937		\$ 130,222	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,002,735	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,632	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 30,488	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,856	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 867,485	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Mulberry Manor

0025411

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 1,704

Description: Copy Machine 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.

Facility Name & ID Number Mulberry Manor # 0025411 Report Period Beginning: 1/1/2015 Ending: 12/31/2015
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)	124	320		444
4	Clinical Wages (b)	241	623		864
5	In-House Trainer Wages (c)	512	1,320		1,832
6	Transportation				
7	Contractual Payments	490	490		980
8	CNA Competency Tests				
9	TOTALS	\$ 1,367	\$ 2,753	\$	\$ 4,120
10	SUM OF line 9, col. 1 and 2 (e)	\$ 4,120			

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	<u>2</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>2</u>
2. From other facilities (f)	
TOTAL TRAINED	4

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

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

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 1/1/2015Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 738,002	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	143,014		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)	1,623,894		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,504,910	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,146		14
15	Leasehold Improvements, at Historical Cost	270,439		15
16	Equipment, at Historical Cost	318,045		16
17	Accumulated Depreciation (book methods)	(525,707)		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)	\$ 64,923	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,569,833	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 30,609	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	52,950		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	(54)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Credit Cards Payable</u>	4,207		36
37	<u>Payroll Deductions Payable</u>	2,141		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 123,253	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	9,303		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>N/P : Pilot House</u>	1,665		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 10,968	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 134,221	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,435,612	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,569,833	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,482,266	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,482,266	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(46,654)	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)	\$ (46,654)	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)	\$ 2,435,612	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Mulberry Manor# 0025411Report Period Beginning: 1/1/2015Ending: 12/31/2015

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 1,915,443	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,915,443	3	
B. Ancillary Revenue				
4	Day Care	464,230	4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 464,230	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements	3,780	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)	\$ 3,780	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***	364	25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 364	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28	Federal Income Tax Return Due to '14 Loss	190,774	28	
28a	Loss on Sale of Assets	(1,847)	28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 188,927	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,572,744	30	

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	384,453	31	
32	Health Care	1,409,751	32	
33	General Administration	432,879	33	
B. Capital Expense				
34	Ownership	279,476	34	
C. Ancillary Expense				
35	Special Cost Centers		35	
36	Provider Participation Fee	111,200	36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,617,759	40	
41	Income before Income Taxes (line 30 minus line 40)**	(45,015)	41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (45,015)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* 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:

1/1/2015

Ending:

12/31/2015

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	2,040	2,080	\$ 50,547	\$ 24.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,040	2,128	33,328	15.66	3
4	Licensed Practical Nurses	5,282	5,440	79,988	14.70	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,987	2,083	24,758	11.89	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,550	2,682	43,803	16.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	2,499	2,643	31,424	11.89	15
16	Dishwashers					16
17	Maintenance Workers	2,450	2,538	37,137	14.63	17
18	Housekeepers	2,052	2,094	27,616	13.19	18
19	Laundry					19
20	Administrator	2,080	2,080	102,462	49.26	20
21	Assistant Administrator	520	520	11,993	23.06	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,015	2,055	30,472	14.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	3,586	3,996	81,973	20.51	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	52,674	54,604	593,494	10.87	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	81,775	84,943	\$ 1,148,995 *	\$ 13.53	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			35	
36	Medical Director	104	7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	5	160	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	87	3,075	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	81	3,250	10a-3	45
46	Other(specify)				46
47	Psychologist Consultant	102	4,100	10a-3	47
48	See pg. 24		7,100	10a-3	48
49	TOTAL (lines 35 - 48)	379	\$ 24,885		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JoAnn Keller	Administrator	50	\$ 102,462	Workers' Compensation Insurance	\$ 32,632	IDPH License Fee	\$	
Susan Middleton	Asst. Admin.	0	11,993	Unemployment Compensation Insurance	10,280	Advertising: Employee Recruitment	2,263	
				FICA Taxes	86,162	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	14,614	Patient Background Checks		
				Employee Meals	600	See Pg. 24	8,172	
				Illinois Municipal Retirement Fund (IMRF)*		kel-Tech Allocation	1,140	
				Misc. Employee Benefits	(175)			
				kel-Tech Allocation	9,384			
				Less: Staff Meals	(600)	Less: Public Relations Expense	()	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 114,455	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
				\$ 152,897		\$ 11,575		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description	Amount			Description	Line #	Amount	Description	Amount
	\$					\$	Out-of-State Travel	\$
							In-State Travel	
							Food/Fuel/Hotel for Seminar	558
							Seminar Expense	
							CEU's	486
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,044	
C. Professional Services								
Vendor/Payee	Type	Amount						
Barnett & Levine	CPA	\$ 2,845						
kel-Tech Mgmt. Co.	Accounting Services	98,274						
FMGR	Legal	1,508						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 102,627					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. \$ 7,337 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. \$ 111,200
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? Yes 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. \$ 600 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Mulberry Manor, Inc.
Sch. V, Line 20, Col. 8
Analysis of Dues, Fees & Subscriptions
2015

Subscriptions	\$	323
Memberships		
MES of IL		175
Sams Club Membership		90
Contributions		100
Fingerprinting		675
Secretary of State		200
W/C AWIS Annual Fee		6,000
License Renewals		323
Affordable Care Act Fees		386
IDPH Penalty		1,500
Advertising		1,002
Less		
Advertising		(1,002)
Contributions		(100)
IDPH Penalty		(1,500)
	\$	<u>8,172</u>

Mulberry Manor, Inc.
 Reconciliation Sch. XI, Col. 6, Line 83 to
 Sch. V, Line 30, Col. 8
 2015

Sch. XI, Col. 6, Line 83	\$ 30,488
kel-Tech Mgmt Allocation	4,494
Sch. V, Line 30, Col. 8	<u>\$ 34,982</u>

Mulberry Manor, Inc.
 Sch. V Line 36, Col. 3
 2015

Insurance - Officers's Life	246
Bad Debt	131
Tax Penalties	429
Total	<u>\$ 806</u>

Mulberry Manor, Inc.
 Details for Sch. XI, Line 79
 2015

Use	Model, Make and Year	Year Acquired	Cost	Current Book Deprec	S/L Deprec.	Adjust.	Life In Yrs	Acc. Deprec.
Healthcare		2007	35001	1775	0	-1775	5	35001
	2007 Buick Terraza							
Healthcare		2008	1880	0	0	0	5	1880
	1999 Ford Transmission							
Healthcare		2013	24723	0	4945	4945	5	12362
	2010 Ford Econoline							
Healthcare		2015	4466	2345	112	-2233	5	112
	United Access Lift							
			61604	4120	5057	937		49355

Mulberry Manor, Inc.
Sch. XVIII Sec. B Line 48
2015

	# Hours	Total Cost	Sch. V Ref.
Psychiatric Consultant	80	6000	10a-3
Behavior Therapist	12	1100	10a-3
Total		<u>\$ 7,100</u>	

Mulberry Manor
Analysis Allocated Hours & Wages
Sch18, Line 29 & 30, Col 1-4
2015

Susan Middleton, QSP, Assistant Administrator
Allocation of wages:

QIDP	75%	35,979
Asst. Admin.	25%	<u>11,993</u>
Total	100%	<u>\$47,972</u>
